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1943

*Schenectady County*

DEPARTMENT OF  
PUBLIC WELFARE



**MEDICAL MANUAL**

*February 1, 1943*

LEO H. VOSBURG  
Commissioner



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Social Welfare  
Schenectady co., N.Y. Dept. of  
Public Welfare

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## Introduction

This Manual of Regulations governing the Administration of Medical Care to the Indigent has been prepared by the Schenectady County Department of Public Welfare with the assistance of the State Department of Social Welfare (Medical Division) and represents an attempt to state some of the policies and procedures regarding the Administration of Public Medical Care in Schenectady County. These policies and procedures have been developed as the result of many years of experience in the administration of a public-medical program which provided the physician-of-choice authorized on a fee-for service basis. This experience has taught among other things the essential quality of professional supervision, control, and regulation.

The success or failure of this Medical Care Program depends upon the cooperation of the individual members of the participating professions and their organized professional societies.

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## Foreword

The creation of a Division of Medical Care headed by a physician who is charged with the administration of a program of medical care which will provide at a reasonable cost to the taxpayer, standard types of medical diagnosis and treatment for recipients of public assistance, has been established by this Department in conjunction with the New York State Department of Social Welfare.

The preparation of this Manual represents many months of diligent work on the part of the staff of the Division of Medical Care; work which was shared by the Medical-Social Staff of the State Department of Social Welfare and by the medical, dental and pharmaceutical representatives of the Professional Advisory Committee. To all of these the Commissioner extends his appreciation for their efforts in making this Manual possible.

LEO H. VOSBURG  
*Commissioner*

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## KEY TO ABBREVIATIONS

A.B. ....	Assistance to the Blind
B.C.W. ....	Aid to Dependent Children (Administered by the Board of Child Welfare.)
C.W.S. ....	Child Welfare (Children under care and su- pervision of the Child Wel- fare Bureau.)
H.R. ....	Home Relief
O.A.A. ....	Old Age Assistance







## Basic Policies

1. Basic to the medical program of Schenectady County Department of Public Welfare is the recognition by Public Welfare officials, physicians, hospital administrators, and all other professional personnel and vendors of medical supplies, of the Public Welfare Commissioner's legal responsibility and authority\* to provide medical care for all persons under his care, and for such persons, otherwise able to maintain themselves, who are unable to secure necessary medical attention.

2. The medical program of the Schenectady County Department of Welfare and the Schenectady County Board of Child Welfare includes the full and proper use of existing medical resources, local, State and Federal, as well, as local tax supported and voluntary institutions, as supplementary to the medical program of the Welfare Department and the Board of Child Welfare.

3. The administrative responsibility for the authorization and issuance of medical care is vested by the Commissioner of Public Welfare in a Central Medical Unit under the direction of a part time physician, known as the Medical Consultant. The authorization of medical care for Board of Child Welfare patient rests with the Senior Investigator of the Board of Child Welfare staff, under the direction of the Medical Consultant. The Medical Consultant shall be supported by a Medical Advisory Committee composed of representatives of the Schenectady County Medical Society, a representative of the dental profession and a representative of the pharmacists. It is recognized that sound administration of a medical program requires:

- a. Professional medical judgment and controls given by a physician.
- b. Simplified and smoothly operating procedures to effect the referral of patients to physicians, hospitals etc., for treatment.
- c. Definite provision for keeping the Social Service staff informed of health, medical and medical-social treatment needs of their clients.
- d. An accounting system, which shall meet the regulations of the State Department of Social Welfare and local fiscal regulations.

4. This program shall apply to the following:

- a. All categories of Public Assistance administered by the Schenectady County Department of Public Welfare (Old Age Assistance, Assistance to the Blind and non-settled Home Relief.
- b. Aid to Dependant Children (administered by the Schenectady Board of Child Welfare.)
- c. Home Relief administered by the Towns.
- d. Child Welfare.

5. Public Welfare Officials recognize the need and value of detailed, written agreements with physicians, hospitals and other persons participating in a medical care program, which state clearly the responsibilities undertaken by each as well as procedures, and financial payments involved.

\* Social Welfare Law—1941—Article 5, Title 4, Section 184

6. The Schenectady County Department of Public Welfare and Board of Child Welfare assume the responsibility for establishing and maintaining continuous medical records to show:

- a. Total treatment costs according to type of service, such as physician's treatment, nursing care, drugs, hospital care, appliances, etc.
- b. Diagnostic and treatment records of each individual patient, including costs.
- c. Administrative costs.

7. The Schenectady County Department of Public Welfare accepts the responsibility for joint planning and periodic case conferences between the Central Medical Unit, and the members of the social service staff, including Town welfare officers, for determination by physicians of medical needs and social service to determine financial eligibility for patients applying to the Department of Public Welfare for medical assistance only. There shall also be conferences between the Medical Advisor and members of the social service staffs, through the Case Supervisor, Children's Agent, and/or Senior Investigator of Board of Child Welfare whenever the need of such conference is indicated from either the medical or social point of view, in the interest of the patient, the Department of Public Welfare and/or the Board of Child Welfare.

8. This Medical Manual of the Schenectady County Department of Public Welfare and the Schenectady County Board of Child Welfare sets forth medical policies, procedures, fee schedules, etc., relating to participating professional personnel and vendors. Copies are available to all professional participants, members of the social service staffs, all cooperating agencies or institutions in any way involved in the medical program, and to such other persons as the Commissioner of Public Welfare or the Chairman of the Board of Child Welfare may designate.

9. The provisions of this Medical Manual may be amended on request of professional and/or Department of Public Welfare participants in the medical program after review by the Commissioner of Public Welfare, the Board of Child Welfare, the Medical Advisory Committee and with the approval of the State Department of Social Welfare.

All participating professional personnel and welfare staffs shall be given sufficient notice before the effective date of any amendment.

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### **FUNCTIONS OF THE MEDICAL CONSULTANT**

1. The Medical Consultant shall act as liaison officer between the Department of Public Welfare, the Board of Child Welfare, the Town Welfare Officers, the medical profession, and vendors.

2. He shall interpret to the medical profession and other medical vendors, hospitals, institutions, etc., the regulations and requirements of the State Department of Social Welfare, as they relate to the Schenectady County Medical program.

3. He shall interpret to the medical profession the regulations of the Schenectady County medical program.

4. To the Welfare Departments, he shall interpret the professional medical aspects of a medical care program.



5. The Medical Consultant shall grant specific written approval or disapproval from the professional medical viewpoint on medical items requiring such action, but the authorization of expenditures for such items is the responsibility of the welfare departments since only welfare officials, or their delegates, may authorize expenditures of welfare funds after proving eligibility of the patient for assistance.

*(For list of items requiring approval by the Medical Consultant, see below)*

6. The Medical Consultant's written approval and signature shall be recorded against the item as shown on the Individual Patient's Medical Record—Form M-4.

### ITEMS OF MEDICAL CARE REQUIRING SPECIFIC APPROVAL BY THE MEDICAL CONSULTANT

1. All requests for medical care in home or office.
2. Drugs, other than United States Pharmacopoeia or National Formulary and those accepted by the State Department of Social Welfare for reimbursement. (See page 16.)
3. Nursing care in the home and special nursing care in hospital; placement in a nursing or convalescent home.
4. All appliances costing over \$10.00, all eyeglasses and all drugs, medical or sickroom supplies costing over \$5.00.
5. Hospital admissions, with the exception of medical or surgical emergencies.
6. Dental care and/or treatment in excess of the provisions of this medical manual.
7. Dentures, and repair of dentures costing over \$10.00
8. All diagnostic X-rays taken in physicians' offices, except in medical or surgical emergencies.
9. All X-ray treatment.
10. All radium treatment.
11. Care for tuberculosis patients being care for in their own homes, after receipt from the Public Health Officer of a written statement that it is in the best interest of the patient and not harmful to the members of the family or the community that he be taken care of in his own home.
12. Services of specialists as consultants or for treatment, with the exception of eye examinations by ophthalmologists.
13. Physiotherapy (all modalities) in excess of the first five treatments.
14. Special Diets.



# Statement for Physicians

## ***I. Policies***

A. The medical care program for all persons under care of the public welfare district, and for those persons able to maintain themselves but not able to meet their necessary medical expenditures, is based upon the patient's choice of physician, preferably the nearest to his home, and paid for on a fee for service basis.

B. All physicians licensed to practice in the State of New York may participate in this program. The Commissioner of Public Welfare by virtue of his legal responsibility\* to provide medical care may, after conference with the Medical Advisory Committee and Medical Consultant, eliminate from this program any physician who violates the rules and regulations of this Medical Manual.

C. The Commissioner of Public Welfare hereby delegates the responsibility for the administration and issuance of authorization of medical care for patients under his care to the Central Medical Unit.

The Board of Child Welfare delegates the same responsibility to its Senior Investigator, with direction by the Medical Consultant.

The same responsibility is vested in the Children's Agent, with direction by the Medical Consultant.

D. All ambulatory patients, shall, in so far as is practicable receive care in physician's office and/or available clinics.

E. The basis of authorization shall be not more than ten home and/or office visits in one calendar month on one authorization.

## ***II. Procedures***

A physician requesting authorization to give service to recipients of assistance, any person under care of the public welfare district, and expecting payment from Welfare or Board of Child Welfare funds shall follow the procedures outlined below:

### **A. GENERAL MEDICAL CARE**

#### **1. AUTHORIZATION**

a. The patient in need of a physician's services shall communicate directly with the physician of his choice.

b. The physician shall, within 48 hours, (Sundays and legal holidays excepted) of his first visit to the patient, send notice of his call by forwarding the official Notice and Request for Authorization Form M-1, furnished by the welfare departments, to the Medical Unit in the County Welfare Office.

c. If the card (Form M-1) is postmarked within 48 hours of the first visit, the number of calls requested is reasonable in relation to the diagnosis and the patient is eligible for assistance, the physician shall be sent an

\* Social Welfare Law—March 1, 1941, Article 5, Title 4, Section 184

authorization (Form PA-210M) for the number of visits he has requested, which visits shall be within the calendar month.

If however, the number of calls does not appear reasonable in relation to the diagnosis or if there is any other medical question, the Medical Consultant shall communicate with the physician and, on the basis of their joint decision, a number of calls shall be agreed upon and approved for authorization.

d. When a notification card (Form M-1) is received and it is found that the patient is not in receipt of assistance, the physician will not receive an authorization Form PA-210M, but he shall be immediately notified in writing that the case has either been referred to the proper agency, is under investigation for eligibility, or is definitely not a responsibility of any welfare department. If investigation shows that the patient is found eligible for assistance, the authorization Form PA-210-M will be issued to the physician. If the patient is not eligible for assistance, the physician shall not expect payment of his bill from any welfare department.

## 2. EXTENSION OF AUTHORIZATION

When medical care beyond the number of visits originally authorized in a calendar month is necessary, the physician shall request further authorization by forwarding a new card (Form M-1) showing the additional number of visits necessary and the reason why further care is needed. (See page 6.)

## B. DRUGS

1. Physicians are expected to dispense the usual drugs in the course of a home or office visit without extra charge. (Eg. Aspirin and such medicine as needed in an emergency.)

2. All drugs are restricted to those officially recognized in the United States Pharmacopoeia, the National Formulary, and those drugs accepted for reimbursement by the State Department of Social Welfare. (See list page 16.)

3. When in a treatment plan for a specific patient, a physician wishes to prescribe drugs other than those noted above, he shall first secure the specific written approval of the Medical Consultant. Categorical approval shall not be given for such drugs unless they are placed on the State approved list.

4. Specific approval by the Medical Consultant is also required for drugs in group 2 of the State List of drugs accepted for reimbursement. (See list page 16-17.)

5 When in a rural area, the physician dispenses other than the usual drugs and/or prescriptions, he shall attach to his bill for services, the prescription, name and amount of each drug and cost of any drugs dispensed, if he wishes payment for the same.

6. The physician on issuing a prescription for a patient shall note on his prescription blank the initials "P.A." or "pending P. A." thus indicating to the pharmacist that medical care has been authorized, or authorization is pending determination of eligibility.

7. There shall be no refills of a prescription without a new prescription from the physician. Exception: Insulin and equipment for diabetic patients may be

furnished for a month at a time, or on standing order from the physician, good for not exceed 3 month.

8. Sick room supplies shall be prescribed for individual patients. Those costing over \$5.00 shall have the specific approval of the Medical Consultant. Procedure same as for drugs.

### **C. DENTAL CARE**

When dental care in excess of that permitted by the regulations of this Manual, is recommended, the Medical Consultant may request, and the physician shall provide a written statement giving his opinion as to the need for extensive dental care in relation to the patient's physical condition.

### **D. DENTURES**

Recommendation for dentures shall be supported by a written statement from the patient's attending physician, in which he states specifically the physical findings, the diagnosis, the treatment plan followed and the results therefrom, as well as the relationship between the patient's age, physical condition, employability and the lack of dentures. He shall also state how long the patient has been edentulous.

### **E. EYE EXAMINATIONS**

Eye examinations with the exception of classifying examination for Assistance to the Blind, shall be made in available clinics. In exceptional instances, for example where a patient is not physically able to go to a clinic, eye examination may be made by, preferably, an ophthalmologist.

1. All classifying examinations for Assistance to the Blind shall be made by an ophthalmologist, who shall complete the classification Form AB-18.

When no ophthalmologist is available, eye refractions may be made except for Assistance to the Blind cases, by an optometrist provided this has been recommended by the patient's physician on the official notification card, Form M-1. The authorization to an optometrist shall cover the cost of glasses only and no fee shall be paid for refraction.

2. If a patient is in need of continued treatment of an eye disease, the ophthalmologist, who wishes to treat the patient shall follow the same procedure as any other physician as described in item A-1 and B, pages 6-7.

### **F. HOSPITAL CARE**

#### **AMBULATORY PATIENTS**

Except in medical or surgical emergencies, physicians wishing to hospitalize an ambulatory patient shall refer him to the appropriate clinic at Ellis Hospital for examination and shall forward to the County Welfare Office, Medical Unit, the notification card, Form M-1 stating that hospital care is being recommended and the patient has been referred to clinic.

#### **BED PATIENTS**

Except in medical or surgical emergencies, physicians wishing to hospitalize a bed patient shall submit Form M-1 to the County Welfare Department, Medical Unit for review and approval by the Medical Consultant before sending the patient to the hospital.



## EMERGENCIES

In case of a medical or surgical emergency for either ambulatory or bed patients, the physician may notify the County Welfare Department, (Medical Clerk) by telephone, but shall follow this within 48 hours (Sundays and legal holidays excepted) by submission of Form M-1.

If in a medical or surgical emergency, no authorizing official can be reached, the patient may be sent directly to the hospital, but the physician shall submit Form M-1 as noted above.

4. If a physician wishes to hospitalize a patient for the purpose of diagnostic study only, he shall make clear on his request (Form M-1) the reasons for wishing diagnostic study, as well as showing what treatment has been followed and the results therefrom.

5. Attending physicians, shall in all cases be promptly notified, in writing (Form M-13) of approval or disapproval of the recommendation for hospitalization.

## AMBULANCE

Except in medical or surgical emergency, physicians wishing ambulance service for their patients shall make the request to the Medical Clerk in the County Welfare Office. This request, if made by telephone shall be confirmed by forwarding the official notification card Form M-1 within 48 hours (Sundays and legal holidays excepted) of the telephone request.

In emergencies, the physician may make direct request for ambulance service to the hospital but shall forward written confirmation as described above.

## G. NURSING OR BEDSIDE CARE

### 1. IN THE HOME

a. Except in medical or surgical emergency, a physician prescribing nursing or bedside care in a patient's home, shall first secure specific approval of the Medical Consultant. The physician shall submit Form M-3 completely filled out to the County Welfare Department, Medical Clerk.

b. In emergencies, the physician may make his request by telephone, but shall submit Form M-3 within 48 hours, (Sundays and legal holidays excepted.)

c. The physician shall in every case be notified in writing (Form M-13) whether or not his request has been approved.

d. If nursing or bedside care beyond the originally authorized period is needed, the physician shall re-submit his request following the procedure noted in paragraph 1-a above.

### 2. CARE IN NURSING HOMES FOR INVALIDS OR CHRONICALLY ILL PATIENTS

a. Placement in a nursing home shall be made only on written recommendation of the attending physician that in his best judgment the patient is suffering from a physical condition or illness, which does not require continued hospitalization or institutional care, and that not satisfactory arrangements can be made in the patient's place of abode. The physician's statement shall indicate the kind of care the patient needs as well as his opinion as to the suitability of the specific Nursing Home for the individual patient.

b. Recommendations for placement in a nursing home shall be reviewed, for purpose of specific approval, by the Medical Consultant and Case Supervisor, or Senior Investigator for Board of Child Welfare and Children's Agent for Child Welfare, so that both medical and social factors are fully considered. Except in medical or surgical emergencies, such review and approval shall be made before placing the patient in the nursing home.

## H. OBSTETRICAL CARE

1. The decision as to home or hospital delivery shall be made by the attending physician and the patient.

2. When the physician decides that delivery shall be in the hospital, he shall, in so far as is practical, refer the patient to the hospital clinic for prenatal care.

3. In cases of home delivery, the physician may either give prenatal care, or refer the patient to the prenatal clinic at Ellis Hospital.

NOTE: Nursing care for home deliveries is furnished by the Public Health Nursing Association on request of physician or welfare department.

4. In case of either home or hospital delivery the physician shall forward the Form M-1 to the Medical Unit, County Welfare Office, and shall indicate thereon whether or not he is referring the patient to the prenatal clinic or expects to give the prenatal care himself.

5. Authorization for obstetrical care shall be as follows:

### a. Home Delivery

(1) One authorization to cover prenatal care, with a maximum of 10 visits: and

(2) One authorization for delivery in the home and post partum visits, including a final gynecological examination six weeks after delivery, or at least before the mother assumes her household duties.

### b. Hospital Delivery

(1) Authorization may be issued for the number of prenatal visits made up to the point of referral to clinic for prenatal care, or referral to hospital for delivery.

(Maximum, ten visits.)

(2) Authorization for admission to hospital.

(See Statement for Hospitals pages 18-19-20.)

## I. PROSTHETIC APPLIANCES

### 1. Orthopedic Appliances

a. Recommendations for orthopedic appliances before referral to the Medical Consultant for review shall have been reviewed and written recommendation made by an orthopedic specialist or a surgeon with S. A., S. B., or S. C. rating. The recommendation of the orthopedic specialist or surgeon shall be reviewed by the Medical Consultant as part of the basis on which his decision for prior specific approval or disapproval is made.

Note: Orthopedic appliances costing over \$10.00 for persons up to 21 years of age are the responsibility of the Children's Court and shall not be supplied by the County Welfare Department.

### 2. Surgical Appliances

Surgical appliances shall be authorized only on written prescription. All those costing over \$10.00 shall be submitted to the Medical Unit for review and *prior* specific approval by the Medical Consultant before authorization is issued.

### 3. *Eyeglasses*

Individual authorization shall be requested for each pair of glasses prescribed. Specific approval of the Medical Consultant shall be secured on all glasses costing over \$10.00.

## J. PRE-PLACEMENT EXAMINATION FOR CHILD WELFARE

There shall be a complete physical examination including Wasserman and Tuberculosis tests for each child for whom Child Welfare care is under consideration. Physicians making such examinations shall forward the notification card Form M-1 together with their findings and recommendations on Form CW-17 to the Medical Unit, County Welfare Office. There shall also be an annual routine re-examination for each child under Child Welfare supervision.

## K. PHYSICAL EXAMINATION FOR EMPLOYABILITY: ELIGIBILITY FOR BOARD OF CHILD WELFARE

When patients are referred by any welfare office for physical examination to determine employability, the examining physician shall forward the notification card Form M-1 and shall also forward a detailed written report Form M-14 of his findings and specific recommendations as to the degree of employability of the patient.

## L. PHYSIOTHERAPY

### A. *In Physician's Offices*

1. Physicians shall submit request in the same way as for home or office care, by submission of Form M-1. (See Item II-A—pages 6-7.)
2. If more than five treatments are requested, the specific *prior* approval of the Medical Consultant shall be secured.
3. The physician in requesting approval, shall submit a written statement giving diagnosis, progress made as the result of the five treatments already given, the number of additional treatments needed, and the prognosis.

### B. *In Hospital—For Out-Patients Only.*

1. The hospital shall submit a written request for authorization of physiotherapy.
2. Procedure is the same as in Item A-2 and 3 above.
3. Authorization shall be issued as for hospital care on Form M-7.

## M. SICKROOM SUPPLIES (See Drugs—Item D page 15.)

## N. SPECIALIST'S SERVICES

For the purposes of the Schenectady County Medical Manual a specialist is a physician, who is recognized by his colleagues as qualified by training and experience in a particular field of medicine or surgery and who restricts his practice to that field. Indications of formal recognition are an "S" rating by the Medical Compensation Board of the County Medical Society, or recognition of personal proficiency as attested by a written statement from the County



Medical Society or listing as a "Diplomate" of one of the American Boards in the latest edition of the Directory of Medical Specialists.

2. When requested by an attending physician by submission of Form M-1, authorization for the services of a specialist on a consultative basis, shall be given only when such service is not available through the Ellis Hospital Clinics, or when the patient is physically unable to attend the clinic.

3. Treatment by specialists shall likewise be authorized only when such treatment is not available at the Ellis Hospital Clinics.

4. In cases requiring continuing treatment by a private specialist, specific approval shall be secured from the Medical Consultant.

5. The specialist shall request authorization for his services by submission of Form M-1. (See Item II-A pages 6-7.) Exception: Referral to an ophthalmologist for refraction or treatment, or qualifying examination for assistance to the Blind, does not require approval of the Medical Consultant.

#### **O. RADIUM TREATMENT**

1. All requests for radium treatment shall have the *prior* specific approval of the Medical Consultant before authorization is issued.

2. Requests for approval shall be made by the submission of Form M-12.

#### **P. X-RAY**

##### **1. Diagnostic (exclusive of hospital)**

(a) Except in medical or surgical emergency, requests for diagnostic x-ray shall have the *prior* specific approval of the Medical Consultant before authorization is issued.

(b) Requests for approval shall be submitted on Form M-10.

(c) In medical or surgical emergencies, the physician may request authorization by telephone, but shall submit Form M-10 within 48 hours (Sundays and legal holidays excepted) of his telephone request.

##### **2 Treatment**

(a) Procedure the same as for Radium Treatment, Item O-1, above.

(b) Request for approval shall be made by the submission of Form M-11.

#### **Q. VENEREAL DISEASE TREATMENT**

Since the treatment of a venereal disease is the responsibility of the Health Department, physicians, who treat patients for this disease shall not expect payment for their services from any welfare department in Schenectady County.

### **III. Preparation and Payment of Physicians Bills**

A. Physicians shall return the completed Forms PA-210-M as soon as the services authorized thereon have been rendered. By the 7th of the month, following that in which the authorized medical service was given, all Forms PA-210-M previously sent the physicians, shall be returned to the welfare office which issued them. Prepared County vouchers which have been sent to the physicians, shall be signed, notarized and returned within three days of receipt.

B. By the 14th of this same month, the Medical Clerk, Town Welfare Officer, or Board of Child Welfare Clerk shall have completed the County Vouchers for all physicians' bills which are to be paid by check drawn to the physician.

C. The payment of bills for which Forms PA-210-M are complete and correct, and the County vouchers properly signed and notarized, shall be made in the following ways:

1. For Old Age Assistance, Aid to the Blind, and Board of Child Welfare, a check shall be drawn to the patient, who is responsible for payment of his physician's bill. In individual cases, in which past experience has proven the necessity of indirect payment the Department of Public Welfare and/or Board of Child Welfare may pay a physician's bill by voucher.

2. For Home Relief and Child Welfare the check shall be drawn to the physician.

#### ***IV. Fees***

(See schedule of Reimbursable Charges pages 27, 28, 29, 30, 31, 32 )

# Statement for Pharmacists

## *I. Policy*

A. All drugs are restricted to those officially recognized by the United States Pharmacopoeia, the National Formulary and the list of drugs accepted for purposes of reimbursement by the State Department of Social Welfare. (See page 16.)

B. In specific instances and only with the specific approval of the Medical Consultant may drugs in Group 2 of the State list and drugs other than those noted above be approved when considered essential in the treatment of an individual patient. Categorical approval shall not be given for such drugs, unless they are placed on the State approved list.

C. Usual drugs shall be dispensed by physicians in the course of home or office visits at no extra charge. (Eg. Aspirin or such medicine as needed in an emergency.)

D. THERE SHALL BE NO REFILLS OF PRESCRIPTION.

Exception: Insulin and supplies for diabetics may be prescribed for a month at a time or on standing order, good for not more than three months, from the attending physician.

## *II. Procedures*

A. A pharmacist wishing to dispense drugs to patients in receipt of assistance and expecting payment from welfare and/or Board of Child Welfare funds shall follow the procedures outlined below:

1. On receipt of a prescription brought to the drug store by a patient or his agent, the pharmacist shall check the prescription blank for the initials "P. A." or "Pending P. A.", which indicates to him that the drugs have been prescribed by a physician authorized by a department of welfare to give medical attendance and that the cost of the drugs will be met from welfare or Board of Child Welfare funds, or that the case is pending investigation for eligibility for assistance.

2. If a prescription is presented, which does not have the above described identifying data thereon, the pharmacist, before filling the prescription, shall communicate with the Medical Clerk for County cases, the Town welfare officer for Town cases or the Senior Investigator for Board of Child Welfare cases. If he is informed that the case is accepted, he shall fill the prescription and note thereon the name of the person who gave oral authorization and the date. If he is informed that the case is not accepted, he shall understand that the cost thereof will not be met from welfare or Board of Child Welfare funds.

3. When the pharmacist has filled a prescription, he shall inscribe the prescription number, the cost and the date of filling on the prescription and secure the signature of the patient or his agent, who receives the drugs from the pharmacist. The signature and the relationship of the agent to the patient shall appear either on the face or the back of the prescription blank.



4. If a patient requests drugs or medical supplies of any kind and expects a welfare department to pay the bill but does not present a prescription for the same, the pharmacist, if he fills the request, shall not expect payment from the welfare department.

5. When the pharmacist has filled a prescription, numbered, dated and priced it, and secured the signature of the recipient, he shall forward the prescription to the Medical Unit, County Welfare Office at least within 48 hours (Sundays and legal holidays excepted) of filling the prescription.

6. In the case of narcotic prescriptions, the pharmacist shall make two copies of the prescription, clearly marked across the face, "NARCOTIC—NOT TO BE REFILLED" and forward both copies to the welfare agency.

7. For prescriptions presented during hours when the welfare departments are closed, the pharmacist may, if he chooses, fill the prescription, but if the prescription does not indicate that the patient is in receipt of assistance, the pharmacist shall notify the welfare office by telephone the following day.

## B. PREPARATION OF BILLS

1. By the 10th of the month following that in which the prescriptions were filled, the pharmacist shall receive from the respective welfare departments, the prepared County voucher.

2. The pharmacist shall sign and make affidavit on all County vouchers and return to the Welfare Department within 3 days of receipt.

## C. PAYMENT OF BILLS

1. The cost of prescriptions shown on the County vouchers will be paid by a check drawn to the pharmacist.

## D. SICKROOM SUPPLIES

Sickroom supplies shall be authorized only on individual prescription for each patient. The procedure is the same as that prescribed for drugs above, except that if any individual item costs over \$5.00 the pharmacist before filling the prescription, shall first secure specific approval of the Medical Consultant. He shall do this by submitting the prescription to the Medical Clerk in the County Welfare Department. The Medical Consultant shall indicate his approval by signing the prescription blank, which shall be returned to the pharmacist for filling.

Procedure following this is same as described above for any prescription, except that payment for supplies issued to recipients of O. A. A.; A. B.; A. D. C., will be paid by the patient who will be given a special grant to cover this need.

## III. Fees

See schedule of reimbursable charges page 49.

NOTE: According to Article XXIV-A-Fair Trade Law-Section 369-a-Price Fixing of Certain Commodities Permitted—Subdivision 3, section 369-a.3: "This article shall not be deemed or construed to apply to, or fix or limit prices at which any commodity may be sold or offered for sale to the State of New York or to any administrative department of the State Government, to any political sub-division of the state, to any municipality, to any public corporation or authority now or hereafter created by the Legislature", etc.

# STATE-APPROVED LIST\* OF NON-OFFICIAL "PROPRIETARY" PREPARATIONS

## Group 1

a. Commonly used non-official (proprietary) preparations accepted for reimbursement when prescribed by a physician.

Adrenalin	Reticulogen; Ventrox; Ventriculin;
Aspirin	etc.
A. P. C. (Aspirin, Phenacetin and Caffein) Tablets	Mercurochrome Seilers (A & A) Tablets
Baby Foods	** Sulfapyridine (Sulfanilamide now USP)
Brewer's Yeast	** Sulfathiazol
Dicalcium Phosphate	Syrup Colcillana
Digitalis Preparations	Vaseline
Ichtyol	Vitamins: (A & D) Cod Liver Oil and Halibut Oil (Now USP XI, Supp. 2)
Insulin; Zinc Insulin; Protamine Zinc Insulin	
Liver Preparations; e. g., Lextron;	

\*Subject to amendment from time to time.

\*\*Sulfapyridine and Sulfathiazol may be obtained by registered doctors of medicine from designated laboratory supply stations in upstate New York for use in treatment of pneumococcal infections in "patients for whom the purchase of the drug would prove a hardship."

## Group 2

b. Non-official or proprietary preparations which are specific, empiric, costly remedies, which are used for the treatment of certain unusual diseases or conditions will be subject to reimbursement only after the physician's recommendations and prescription have been specifically approved in writing by the medical director of an approved local medical plan or by the Division of Medical Care of the State Department of Social Welfare.

Adrenal Cortex	Eschatin
Aluminum Hydroxide: e. g., Amphojel,	Estrogenic Hormone
Creamalin	Estrone
Amniotin	Follacra
Antutrin S	Follutein
Aolan	Glycine (Aminoacetic Acid)
Benzedrine Sulphate	Gynergen
Biologicals (Not available through State Department of Health)	Mandelic Acid
Cortate	Mercuprin
Desoxycorticosterone—Acetate	Monolate
Dihydrotachysterol	Pantopon
Dilantin	Parathyroid Extract
Dilaudid	Pentobarbital, Soluble
Dimen Formon	Percorten
Dimen Formon—Benzoate	Progesterone
Doca	Progynon

Prostigmin Bromide  
 Prostigmin Methylsulphate  
 Salyrgan with Theophyllin  
 Scillaren  
 Sistomensin  
 Sodium Dilantin  
 Testosterone Propionate  
 Theelin  
 Theelol  
 Theobromin (Alkaloid)

VITAMINS:

A & D: e.g., Ergosterol; Viosterol;  
 (Percomorphum Oleum)  
 B: e.g., Thiamin Chloride;  
 Riboflavin; Nicotinic  
 Acid; Vitamin B. Complex  
 C: e.g., Cevitamic Acid;  
 Ascorbic Acid  
 E: Wheat Germ Oil  
 K: Vitamin K.



# Statement for Hospitals

## 1. Policies

### A. RESPONSIBILITY FOR HOSPITAL CARE\*

1. "A public welfare district shall provide needed care for sick and disabled persons in a hospital maintained by the municipality or in any other hospital visited, inspected and supervised by the board. It may contract with such other hospital to pay such sum for the care of sick persons as may be agreed upon.

2. (a) As far as practicable, no patient whose care is to be a charge on a public welfare district, or a subdivision thereof, shall be admitted to a hospital without the prior approval of the public welfare official responsible for such care.

(b) Acceptance of any patient as a public charge shall be in the discretion of the public welfare official.

(c) In any case where the patient is a public charge, the public welfare official may, when in the opinion of a physician the condition of the patient permits, transfer such patient to another hospital or provide care in any other suitable place.

(d) If, in case of emergency, a patient is admitted without prior authorization of the public welfare official empowered to approve payment for such care, and the hospital wishes to receive payment from public funds for such patient, the hospital shall, within forty-eight hours of the admission, Sundays and legal holidays excepted, send to such official a report of the facts of the case, including a statement of the physician in attendance as to the necessity of the immediate admission of such patient to the hospital. If the settlement of the patient is not known by the hospital, such notice shall be sent to the commissioner of the public welfare district in which the hospital is located, and such commissioner shall be responsible for making an investigation to discover whether any public welfare district or the state is liable for payment for the care of such patient. The cost of the care of such patient shall be a charge against the public welfare district only when authorized by the commissioner of public welfare."

### B. CARE OF PATIENTS SUFFERING FROM TUBERCULOSIS\*\*

1. *"The public welfare district shall likewise provide suitable care for patients suffering from tuberculosis in a county or city tuberculosis hospital or in any other hospital or sanitarium approved by the board or in a boarding house approved in writing for this purpose by the health officer in charge of the locality where it is situated."*

C. Except in cases of medical or surgical emergency, hospital authorization shall be issued only after the specific prior approval of the Medical Consultant.

D. If a hospital admits a patient on a private pay basis, and later finds that the patient cannot meet all or part of his bill, and, therefore, wishes to refer the case to the County Department of Public Welfare, the hospital shall forward written notification to the Medical Unit, County Welfare Office, as soon as the patient's inability to pay is determined. Such notification shall contain information regarding the hospital's investigation of the patient's financial

\* Social Welfare Law—March 1, 1941—Article V, Title 4, Sec. 187.

\*\* Social Welfare Law—March 1, 1941—Article V, Title 4, Sec. 188.

status and the basis for the hospital's opinion that the patient is eligible for public assistance.

If the County Department of Public Welfare after proving eligibility for public assistance accepts the case, it shall not be responsible for any costs prior to the receipt of notification from the hospital.

E. Patients shall not be hospitalized for purposes of diagnostic study only, without specific *prior* approval of the Medical Consultant..

F. When a patient hospitalized for a physical disability develops suspected or alleged mental illness, the hospital shall immediately notify the Medical Consultant, or if he cannot be reached, the Medical Clerk. The Medical Consultant shall confer with the hospital attending physician and take necessary steps for the care of the patient, pending his commitment to a hospital for the mentally ill.

G. The following special services for patients in-hospital shall have the specific *prior* approval of the Medical Consultant, except in medical or surgical emergency, before authorization is issued.

1. X-ray therapy
2. Blood transfusion
3. Special nursing care
4. Oxygen

In medical or surgical emergencies, these special services may be instituted but approval and authorization shall be requested within 24 hours. The written request shall indicate clearly the nature of the emergency.

5. Special nursing care in hospital shall be restricted to:

(a) Patients so critically ill that the attending physician feels constant nursing care must be maintained.

(b) Patients in the hospital for a physical disability who become mentally disturbed to such an extent that constant attention is needed, pending their removal to a hospital for the mentally ill.

6. All requests for special nursing care for hospital patients shall be submitted for the specific approval of the Medical Consultant. The procedure is the same as described in item G, page 9.

## **II. Procedure**

### **A. AMBULATORY PATIENTS**

1. Except in a medical or surgical emergency, a physician recommending hospitalization of an ambulatory patient shall refer the patient to the appropriate clinic at Ellis Hospital for examination. The clinic shall forward to the County Welfare Department the recommendation for hospital care, Form M-5.

2. On receipt of Form M-5 it shall be reviewed by the Medical Consultant for approval or disapproval. If the Medical Consultant has any question about the recommendation for hospitalization, he shall confer with the attending physician and/or the clinic physician before making decision. His approval and signature shall be indicated on the Hospital Authorization Form M-7.

3. On all cases, the hospital shall forward "Notice of Admission" Form M-6 to the County Department of Public Welfare within 48 hours (Sundays and legal holidays excepted) of the actual admission of the patient.

4. On approved cases, the Medical Clerk shall then forward to the hospital "Hospital Authorization", Form M-7, authorizing care for the specific period recommended on Form M-6.

5. When the patient is to be discharged, the hospital shall forward "Notice of Discharge" Form M-8 to the Medical Clerk at the County Department of Public Welfare, the day of discharge or at least within 48 hours (Sundays and legal holidays excepted) of the actual discharge of the patient.

### B. BED PATIENTS

1. Except in medical or surgical emergencies physicians wishing to hospitalize a bed patient shall notify the Medical Clerk.

2. The Medical Clerk shall make arrangements with the hospital for the admission of the patient, after the review and approval of the Medical Consultant. The Medical Clerk shall also notify the patient or his family of the arrangements made.

3. Following the admission of the patient, the procedure is the same as described in Item A, paragraphs 3, 4, and 5.

4. In emergency admissions, the hospital shall send "Notice of Admission", Form M-6 as in any other case.

### C. EXTENSION OF HOSPITALIZATION

1. If a patient in hospital requires a longer period of hospital care than that originally authorized, the hospital shall make request for reauthorization promptly before or when the authorized period of care is completed, so that there shall be no gap between periods of authorization.

This request shall be made by forwarding a new "Notice of Admission" Form M-6, stating thereon the reasons why the extension of care is necessary and approximately how long an extension will be needed.

2. All requests for extension of hospitalization are subject to review and approval by the Medical Consultant. Unless an extension is so approved and reauthorized, it is not eligible for payment.

### D. PREPARATION AND PAYMENT OF BILLS

1. By the 7th of the month following that in which authorized hospital care was given, one copy of Form M-7 shall be returned to the Welfare Office. By the 20th of each month, the Medical Clerk shall prepare five copies of the County voucher for Old Age Assistance, Aid to the Blind, and State Charge cases and four copies of the County voucher for all other hospital care. All copies shall be forwarded to the hospital.

2. The hospital shall complete all copies, sign, make affidavit and return all copies to the welfare department, within 3 days of receipt.

3. If there are any extra charges for a patient over and above the daily rate, these shall be shown in itemized detail for each patient as authorized on Form M-7.

4. Bills in order to be considered for payment must be complete, accurate, properly signed and notarized before they can be considered by the welfare department.

5. On receipt of bills if they are correct and complete, properly signed and notarized, a check will be drawn to the hospital in payment of same.

6. One copy of the bill (County voucher) shall be returned to the hospital with the check.

E. FEES—See schedule of reimbursable charges—pages 32-33.



# Statement for Dentists

## I. Policy

A. The dental program of Schenectady County, for recipients of assistance and those others, who are self-maintaining, but can not meet their necessary dental expenses is based on the patient's choice of dentist paid on a fee for service basis, except where dental care is available through already existing facilities as follows:

### 1. School dental clinics

B. Dental care shall be restricted to those extractions, fillings, treatments, and repairs which are necessary for the relief or prevention of pain and for the correction of conditions that interfere with earning capacity, normal development, or that endanger life.

C. All dentists licensed to practice in the State of New York are eligible to participate in this program. However, the Commissioner by virtue of his legal responsibility\* to provide medical and dental care, may eliminate from participation in the program, after consultation with the Medical Consultant and Medical Advisory Committee any dentist, who violates the rules and regulations of this medical manual.

D. An individual authorization shall be requested for each patient.

E. If patients not in receipt of assistance apply for dental care, the determination of dental need shall rest with the Medical Consultant and the determination of financial need with the Social Service Staffs of the Welfare Departments. The dentist shall be promptly informed whether or not the patient is eligible for assistance and if not, he shall understand that the patient is expected to meet his own bill.

F. If dental care in excess of the limitations of this manual is recommended, the Medical Consultant may request the written opinion of the patient's attending physician as to the necessity of the recommended dental care in relation to the patient's health, physical condition, or normal development.

G. Dentures shall be supplied only where there can be demonstrated a direct relationship between health needs and/or employability and the lack of teeth. Specific *prior* approval shall be secured from the Medical Consultant before dentures are authorized. Such approval shall also be secured for replacement or repair of dentures if the cost is above \$10.00.

H. If any dental care, or dentures recommended by the dentist are not approved, the dentist and patient shall be notified.

## II. Procedures

Dentists, who wish to secure authorization for services and fees from welfare, Board of Child Welfare, or Child Welfare funds for services rendered patients under care of the Public Welfare District, shall follow the procedures outlined below:

\* Social Welfare Law—March 1, 1941—Article V, Title 4, Sec. 184.

### A. DENTAL CARE

1. The patient in need of dental care shall go to the dentist of his own choice. The dentist shall give only emergency and/or diagnostic service during the first visit. Within 48 hours of the patient's visit (Sundays and legal holidays excepted) the dentist shall forward to the Medical Unit, County Welfare Department, the Dentist's Notification Card, Form M-2, showing emergency care given, cost thereof and itemized estimate of cost of any additional dental care recommended. This statement shall specifically state the teeth in need of care, type of care given, the nature of the materials used, and the individual charge for each item.

Note: In exceptional cases, in which the dentist finds it necessary to give more than emergency or diagnostic care during the first visit, he shall first secure verbal authorization, by telephone, from the Medical Clerk. Authorization may be given only if the cost of the care is within the fee schedule and the total cost within \$30.00. Such verbal authorization shall be followed by the submission of the dental card, Form M-2, within 48 hours (Sundays and legal holidays excepted) of the patient's visit.

2. If the dental care given, and the additional care requested is approved after review by the Medical Consultant, the dentist shall be sent an authorization (Form PA-210-M) specifically indicating the dental work which is being authorized.

3. It shall be the responsibility of the dentist to notify the patient of the appointment for any care authorized in addition to the emergency care given during the first visit.

### B. DENTURES

1. When dentures are recommended, the patient shall be referred to his attending physician for a written statement indicating the physician's opinion of the patient's need of dentures. The physician shall state the disability to be corrected by the use of dentures and the relationship between the lack of dentures and the patient's health, employability, or normal development. There shall also be taken into consideration the opinion of the social service worker of the patient's ability to learn to use dentures, and other socio-medical factors having a bearing on the situation such as age, previous use of dentures, etc.

2. All requests for dentures shall have the specific prior approval of the Medical Consultant before authorization is issued.

3. If dentures are disapproved, both the dentist and the patient shall be notified in writing.

4. The procedure for securing authorization for dentures is the same as described above for dental care—Items A-1 through 3.

## III. *Preparation and Payment of Bills*

1. Dentists shall return completed Forms PA-210-M as soon as the services authorized thereon have been rendered: By the 7th of the month following

that in which authorized dental care was given, dentists shall return to the welfare office which issued them, completed Forms PA-210-M and prepared County vouchers, which have been sent to dentists, shall be signed and notarized, and returned within three days of receipt.

2. By the 14th of the same month, the Medical Clerk, the Town Welfare Officer, or B. C. W. Clerk shall have completed the County vouchers for all dentist's bills which are to be paid by check drawn to the dentists, and forward them to dentist for signature and affidavit.

3. The payment of bills which are correct and complete and the County vouchers properly signed and notarized shall be made in the following ways:

(a) For Old Age Assistance, Aid to the Blind and Board of Child Welfare, a check shall be drawn to the patient who is responsible for paying his dental bill.\*

(b) For Home Relief and Child Welfare, the check shall be drawn to the dentist.

NOTE: If in the judgment of the Commissioner and Case Supervisor, it is deemed advisable in a specific case, the cost of dentures may be paid in two or more monthly installments, or by check drawn to the dentist.

The dentist shall be informed in writing, of such cases.

#### **IV. Fees**

See schedule of reimbursement dental charges, pages 34-35-36-37.

\*In individual cases, in which past experience has proven the necessity of indirect payment the Welfare Department or Board of Child Welfare may pay dentist bill by voucher.



# Medical Resources

## I. Clinics

The following clinics are held at the Ellis Hospital:

### 1. ELLIS HOSPITAL CLINICS

Eye, by appointment	—	Monday 9 A. M.—Wednesday 9 A. M.
Pediatrics	—	Monday 10 A. M.
Ear, Nose, Throat	—	Tuesday 10 A. M.
Gynecology	—	Tuesday 11 A. M.
Medical	—	Tuesday 3:30 P. M.—Wed., 9:30 A. M.
Redressing	—	Tuesday 2 P. M.—Friday 2 P. M.
Surgical	—	Wednesday 10:30 A. M.
Diabetic	—	Wednesday 1:30 P. M.
Neurology	—	Wednesday 10 A. M.
Hypertension	—	Thursday 10 A. M.
Maternal Health	—	Thursday 2:30 P. M.
Proctology	—	Friday 9 A. M.
Skin	—	Friday 10 A. M.
Urology	—	Friday 11 A. M.
Allergy	—	Saturday 11 A. M.
Mental Hygiene	—	By appointment

### 2. SCHENECTADY CITY HEALTH DEPARTMENT CLINICS

*(Open only to patients with City Settlement)*

Dental Clinic	—	For adults—fillings and extraction. (Service limited.)
Venereal Disease	—	State aided — open to all patients
Tuberculosis	—	Twice weekly—City Health Center
Ear, Nose, Throat	—	Twice weekly—City Health Center
Eye, by appointment	—	Twice weekly—City Health Center
Prenatal	—	Weekly—City Health Center
Cardiac	—	Twice weekly—City Health Center
Skin	—	Twice weekly—City Health Center
Gynecology	—	Twice Weekly—City Health Center
Medical	—	Three times week—City Health Center
Orthopedic	—	By appointment

### 3. ORTHOPEDIC CLINIC

Weekly at Sunnyview—for children under 21.

### 4. CHEST X-RAY CLINIC

Weekly at Glenridge Sanatorium (County Tubercular Sanatorium).

## 5. NUTRITION CLINIC

At Vocational School, under the auspices of the County Nutrition Committee. Volunteer staff of physicians, dentists, nurses, nutritionists and social workers with volunteer follow-up by the Medical Auxiliary. Open to any member of the community, usually on referral from the patient's own physician. Results of the nutrition study of the patient and recommendations are referred to the patient's private physician.

## 6. CHILD GUIDANCE BUREAU — CITY SCHOOL SYSTEM

### 7. WELL-BABY CLINICS

Town of Rotterdam — monthly

City Health Center — Tuesday 2 to 4

Hamilton School — Thursday 11 to 12

Franklin School — Thursday 11 to 12

St. Columbus School — Wednesday 11 to 12

Lincoln School — Tuesday 10:30

Van Corlear School — Wednesday 2:00

## II. Nurses

1. Department of Public Welfare — nurses on the staff of the Public Health Nursing Association, a private organization, serve the County for all welfare cases. The Board of Supervisors make an annual appropriation of \$5,000.00 to the Public Health Nursing Association for this work

2. School Nurses—7 school nurses cover the County as follows:

Draper Union Free School District—Town of Rotterdam—Miss Marion Jensen, Nurse.

Duanesburg—School No. 1—Miss Gretchen Small

School No. 4—Miss Augusta Turnbull or Miss Ruth Bartellot.

Glenville—Schools Nos. 3, 10, 11, 12, 14 and 15—Miss Augusta Turnbull or Miss R. Bartellot.

Niskayuna—Schools Nos. 2, 4 and 5—Miss A. Turnbull or Miss R. Bartellot.

Rotterdam—Schools Nos. 1, 3, 7 and 6—Miss A. Turnbull or Miss R. Bartelot.

Schools Nos. 4, 5—Miss Gretchen Small

Schools Nos. 8, 11, 13—Miss E. Rilly

Village of Scotia—Town of Glenville—5 schools, Mrs. Marguerite Malcolm, Nurse Miss Ruth Kearney.

3. One nurse attached to Glenridge Sanatorium, who does follow-up work on discharged tubercular patients.

4. Nursing staff at the County Infirmary consists of:

- A. One supervising nurse
- B. Four registered nurses
- C. Three domestic nurses
- D. Three orderlies

### III. *Salaried Physicians*

1. One physician for the County Home Infirmary, Dr. Edmund D. Colby.
2. 9 School Physicians.

Village of Scotia, Town of Glenville—5 schools—Dr. Herman Galster.

Union Free School District—Town of Rotterdam, Dr. Kenneth Sartoris

Duanesburg—	Schools Nos. 1, 5, 6, 25—Dr. D. C. Walker. School No. 4—Dr. W. J. Swart Schools Nos. 24, 10—Dr. D. C. Walker
Glenville—	Schools Nos. 3, 9, 10, 11, 12, 14, 15, 16—Dr. W. J. Swart Schools Nos. 5, 17—Dr. I. B. Rubin School No. 18—Dr. Herman Galster
Niskayuna—	Schools Nos. 2, 4, 5—Dr. W. J. Swart
Princetown—	School No. 3—Dr. W. J. Swart Schools Nos. 5, 6—Dr. A. P. Squire School No. 2—Dr. D. C. Walker School No. 7—Dr. D. C. Walker
Rotterdam—	Schools Nos. 1, 3, 6, 7—Dr. W. J. Swart Schools Nos. 4, 5—Dr. A. P. Squire Schools Nos. 8, 11, 13—Dr. C. L. Moravec

### IV. *Public Health Officers*

- A. Town of Rotterdam—Dr. A. P. Squire  
Town of Glenville—Dr. Herman W. Galster  
Town of Niskayuna—Dr. Ralph D. Reid  
Town of Duanesburg—Dr. Donald C. Walker  
Town of Princetown—Dr. A. P. Squire

### V. *Salaried Dentists*

Dr. Louis A. Candela—on staff of County Home and Sunnyview Home for Crippled Children. (Eastern New York Orthopedic School.) \$1500.00 appropriated by Board of Supervisors, as part of the appropriation for Venereal Disease.

### VI. *Convalescent Home*

1. COUNTY INFIRMARY—takes all types of cases except contagion, surgery and maternity.

40 beds for woman

40 beds for men—and an 8 bed convalescent ward for women.

### VII. *Special Hospitals*

1. GLENRIDGE SANATORIUM—County Tubercular Sanatorium.

2. SUNNYVIEW—Eastern New York Orthopedic Hospital—supported by private contributions and community fund. Fifteen free beds for orthopedic cases in need of hospitalization.



3. ISOLATION HOSPITAL—Open to City and County contagious cases.

### VIII. *Special School Classes*

1. SIGHT SAVING CLASS—Pleasant Valley School.
2. CLASSES FOR THE DEAF—Pleasant Valley School.
3. SPECIAL CLASSES FOR MENTAL DEFECTIVES—Throughout the City School System.

### IX. *Miscellaneous*

1. Three cent a day hospital plan effective throughout the County.
2. General Electric Co., and American Locomotive Co., have mutual benefit plan for employees, which pays for hospital care in part or total.
3. General Electric Co. has hospital for employees, making a nominal charge for x-rays. There is no charge for the care of "Company injury."
4. American Locomotive Company does not have a hospital but has a staff of one full-time physician, two externes on night duty and one registered full-time nurse. Care given is restricted to industrial injury.

## SCHEDULE OF REIMBURSABLE CHARGES FOR PHYSICIANS' SERVICES

(Exclusive of hospital)

### I. GENERAL MEDICAL CARE

Home calls	\$ 2.00
Office calls	1.00
Night calls (12 midnight to 7 a. m.)	1.00
	in addition to home fee
if more than one patient in the same household is seen or treated during the course of an authorized visit, an allowance of	1.00
in addition to the regular fee, shall be made, regardless of the number of patients seen.	
Physical examination for employment or to determine eligibilty for Board of Child Welfare	1.00
Preplacement physical examination for Child Welfare	1.00

### II. OBSTETRICAL CARE

1. Prenatal care at a rate not to exceed \$1.00 per visit with a maximum for such prenatal care not to exceed 10.00  
and Delivery in the home and necessary postpartum care not to exceed 20.00  
The total charge not to exceed 30.00
2. Hospital delivery-prenatal visits up to referral to clinic or admission to hospital 1.00  
per visit (maximum \$10.)
3. Final gynecological examination after hospital discharge 1.00

4. In cases of complication during pregnancy or delivery, the physician shall submit to the Medical Consultant a written statement of the factors in the case, validating his request for authorization of additional home visits.

### III. SURGICAL PROCEDURES

#### INCISIONS

Incision for superficial abscess as furuncle or boil	
Incision for abscess, small carbuncle with multiple pockets	2.50
Incision of deep abscess or infection	10.00
Paronychia	2.50

#### EXCISIONS

Removal of nail, finger, or toe, including local anaesthetic	2.50
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#### REPAIRS

Suture of:	
Skin: routine fee (home or office) plus for each suture,	.50
Maximum	5.00
Fascia: routine fee (home or office) plus for each suture	.50
Maximum	5.00
Muscle: routine fee (home or office) plus for each suture	.50
Maximum	5.00
Note: if cut so deep as to need suturing of skin, muscle and fascia, fee may be	15.00
if separately sutured and entered on bill.	

#### FOREIGN BODY EXTRACTIONS

Foreign body extractions, intracutaneous	1.00
Foreign body extraction, subcutaneous without anaesthetic	2.50
Foreign body extraction, subcutaneous with anaesthetic	5.00
Foreign body extractions, deep with 21 days after care	12.50

### IV. MISCELLANEOUS

Strapping of:	
Shoulder-routine home or office fee plus	.50
Hip-routine home or office fee plus	.50
Sacro-lumbar spine, home or office fee plus	.50
Thorax-lumbar spine, home or office fee plus	.50

### V. EAR, NOSE OR THROAT

Myringotomy (in office)	2.50*
Myringotomy (in home)	5.00*
*Plus anaesthetic fee if anaesthesia is administered by other than operating physician.	
Epistaxis—routine home or office fee	
Epistaxis—electrocoagulation or electrocauterization	5.00

## VI. OBSTETRICS—OPERATIVE PROCEDURE

Mid forceps application, when clearly indicated	10.00
High forceps application, when clearly indicated	10.00
Internal podalic version with or without extraction when clearly indicated	25.00
Miscarriage, with or without dilatation and curettage, to include ten days after care	25.00

## VII. FRACTURES

Skull non-operative, at a per visit basis	
Maxilla, closed, to include 21 days after care	\$ 12.00
Mandible, (uncomplicated), unilateral, to include 21 days after care	17.00
Mandible, (uncomplicated), bilateral, to include 21 days after care	35.00
Malar, to include 21 days after care	12.00
Nose, to include 21 days after care	8.50
Sub mucous resection, to include 21 days after care	25.00
Clavicle closed, to include 21 days after care	15.00
Scapula, to include 21 days after care	15.00
Vertebrae, contiguous, bodies or laminae, closed to include 60 days after care	35.00
Vertebral processes, non-operative—at a per visit basis	
Humerus, closed, to include 60 days after care	35.00
Radius, or ulna, closed to include 60 days after care	17.00
Colles fracture, closed, to include 60 days after date	22.00
Elbow (including humerus, radius and ulna) closed, to include 60 days after care	25.00
Carpal bones, closed to include 60 days after care	17.00
Metacarpals (one or more), closed, to include 21 days after care	10.00
Finger—one, to include 21 days after care	7.00
Fingers, multiple on one hand, to include 21 days after care	12.00
Femur, closed to include 60 days after care	50.00
Patella, closed, to include 21 days after care	17.00
Tibia, closed, to include 60 days after care	25.00
Fibula, closed, to include 60 days after care	17.00
Tibia and Fibula, closed to include 60 days after care	35.00
Potts fracture, closed, to include 60 days after care	25.00
Metatarsal bones, closed, to include 21 days after care	10.00
Toes—single toe—to include 21 days after care	7.00
Toes—single toe other than first toe, to include 21 days after care	5.00
Sacrum, closed, to include 21 days after care	17.00
Pelvis—one bone, to include 21 days after care	17.00
Pelvis—multiple fracture, to include 21 days after care	25.00
Os Calcis, closed, to include 60 days after care	17.00
Astragalus, closed, to include 60 days after care	15.00
Tarsal bones, other than astragalus, to include 60 days after care	10.00



Multiple fractures not in same hand or foot; add to the greater fee a sum equal to 50% of each lesser not exceeding two times the greater.

### VIII. DISLOCATIONS

Temporo-mandibular	\$ 5.00
Spine, closed to include 60 days after care	50.00
Shoulder, to include 21 days after care	20.00
Elbow, closed, to include 21 days after care	17.50
Finger, reduction and splint	2.50
Finger, open to include 21 days after care	20.00
Hip, to include 21 days after care	37.50
Knee, to include 21 days after care	30.00
Ankle, to include 21 days after care	20.00
Astragalus, closed, to include 21 days after care	25.00
Os Calcis, closed, to include 21 days after care	25.00
Toe, reduction and splint	2.50
Wrist, closed to include 21 days after care	17.50

### IX. DIAGNOSTIC X-RAY (Exclusive of Hospital)

For Physicians with X. D. qualifications

Single Finger	2.00
Single Toe	2.00
Hand (including fingers)	3.00
Wrist (including carpus and lower one third of forearm)	3.00
Forearm mid one third	3.00
Elbow (including upper one third of forearm and supracondyles)	3.00
Humerus mid one third	3.00
Foot (including toes)	3.00
Ankle (including lower three inches of leg)	3.00
Leg mid one third	3.00
Knee (including four inches above and below joint)	3.00
Femur mid one third	3.00
Femur upper one third	3.00
Shoulder joint	3.75
Clavicle	3.75
Scapula	3.75
Chest	5.75
Ribs	5.75
Hip	5.75
Cervical Spine	5.75
Dorsal Spine	5.75
Lumbar Spine	5.75
Any two spinal regions	9.50
Any three spinal regions	13.25

### X. X-RAY THERAPY

Office or hospital

Superficial or low voltage—per treatment	2.00
Deep X-ray or high voltage—per treatment	5.00

# XI. RADIUM THERAPY

(1) Teletherapy or distance therapy for deep seated lesions	\$5.00
(2) Surface radiation, the radium being placed directly in contact with, or a few centimeters from the skin	5.00
(3) Intracavitary radiation inserted directly into any of the body cavities such as vagina, uterus, rectum, mouth, esophagus, larynx	5.00
(4) Interstitial radiation by either removable or permanent implants, i. e. needles or seeds	5.00
Above services reimbursable by arrangement at a rate not to exceed	5.00
For 1000 m. gm. hours or per 1000 m. c.	

# XII. OTHER SPECIAL SERVICES (Exclusive of Hospital)

Parscentesis Abdominalis	5.00
Paracentesis Chest	5.00
Basal Metabolism	5.00
Electro Cardiogram	5.00
Spinal Puncture	5.00

# XIII. GENERAL ANAESTHESIA (Exclusive of Hospital)

Surgical Anaesthesia	5.00
Gas	2.50
Ether, up to one-half hour	2.50
Chloroform, up to one-half hour	2.50
Intravenous	5.00

# XIV. PHYSIOTHERAPY

Per treatment, all modalities	1.00
-------------------------------	------

# XV. SPECIALISTS' SERVICES (Exclusive of Hospital)

## EYE

(1) For complete refraction, involving one visit	2.00
(2) For complete refraction, involving two or more visits	4.00
(3) For complete eye study and classifying examination (including filling in Forms AB-18 for application for Assistance to the Blind.)	5.00
(4) For eye examinations and treatments other than above	2.00
Note:—Refractions by optometrist when patient is referred to him in writing by a physician are to be included in the cost of eyeglasses.	
(5) Removal of a foreign body imbedded in cornea	2.50

## EAR

(1) Complete examination and study including tests (first visit only)	5.00
(2) Subsequent examination and treatment not included in scheduled after care	2.00

## PHYSICIANS' SCHEDULE

### DERMATOLOGY

- |  |      |
|--|------|
| 1) WC 650—Examination, complete, or consultation including necessary tests (WC 114 skin patch test) (first visit only) | 5.00 |
| 2) WC 650 (a) Check up examination of referred patient   | 2.00 |

### PROCTOLOGY

- |  |      |
|--|------|
| 1) WC 665 Anal fissure, divulsion under anaesthesia    | 7.50 |
| 4) WC 668 Hemorrhoids, removal by injection, per visit | 2:50 |
| 8) WC 672 Incision of thrombosed Hemorrhoid            | 5.00 |

### SURGERY, General, Orthopedic, Traumatic

- |   |  |
|---|--|
| (a) General, on per visit basis, when not part of surgical after care.    |  |
| (b) Orthopedic, on per visit basis, when not part of surgical after care. |  |
| (c) Traumatic, on per visit basis, when not part of surgical after care.  |  |

### UROLOGY

- |   |      |
|---|------|
| 1) WC 400—Urologist consultation fee, complete, but not inclusive of cystoscopy, X-ray demonstration (first visit only) | 5.00 |
| 2 WC 401—For each subsequent office visit exclusive of "after care" as specified  | 2.00 |

### ORTHOPEDIC SURGERY

- |   |      |
|---|------|
| 1) Orthopedist (SB)   |      |
| (a) WC 425—Orthopedist, complete examination or consultation (first visit only) | 5.00 |
| (b) WC 426 "Check up" examination of referred patient                           | 2.00 |

### PEDIATRICS (Specialist in Pediatrics)

- |  |      |
|--|------|
| 1) Complete examination including all necessary tests (first visit only) | 5.00 |
| 2) For each subsequent visit   | 2.00 |

## SCHEDULE OF REIMBURSABLE CHARGES FOR HOSPITAL CARE

### I. IN HOSPITAL CARE (Ellis Hospital Only)

- |  |        |
|--|--------|
| A. Adults—over fourteen years of age—per diem rate, all inclusive                            | \$4.75 |
| B. Children—under fourteen years of age—per diem rate, all inclusive, after first three days | 3.50   |



C. Allowable Extra Charges

1. Ambulance, per trip	6.00
(Claim for reimbursement on State Schedule)	
2. Blood for transfusion	5.00
	per 100 c. c.
3. Oxygen—first 5000 cubic feet	.02
	per cubic foot
Over first 5000 cubic feet	.01
	per cubic foot
Oxygen Tent	10.00
Nasal Oxygen	5.00
4. Deep X-ray Therapy	
Per Treatment	3.00
	to ..
	5.00

(Claim for reimbursement on \$3.00)

D. MATERNITY CARE

Ten, eleven or twelve days for mother and child	
—flat rate, all inclusive	54.00
After first twelve days, per diem	4.00

II. OUT PATIENT CARE

1. X-rays—each film	5.00
(Claim reimbursement according to X-ray schedule on page 30.)	
Exception—G. I. Series	15.00
2. X-ray therapy	\$3.00—5.00
(Claim for reimbursement on \$3.00)	
3. Physiotherapy (all modalities) per treatment	1.00

## SCHEDULE OF REIMBURSABLE CHARGES FOR NURSING CARE

I. REGISTERED NURSES

Eight hour duty	\$6.00 per diem
Twelve hour duty	8.00 per diem
Group of two patients	1.00 per diem
In addition to regular charge	

II. LICENSED PRACTICAL NURSES

Per diem	3:50
----------	------

III. HOME MEDICAL AIDE

Per diem	2.00
----------	------

## SCHEDULE OF REIMBURSABLE DENTAL CHARGES

### Dental care (Personal services).

The following schedule of charges for authorized dental care is hereby established, as a maximum basis for reimbursement.

#### ITEM 1. General Provisions and Restrictions

a. Dental care shall be restricted to those extractions, fillings, treatments and repairs which are necessary for the relief or prevention of pain and for the correction of conditions that interfere with normal development, earning capacity or endanger life.

#### ITEM 2. Extractions

Authorized dental extractions shall be reimbursable at not to exceed the following charges.

- |  |        |
|--|--------|
| a. First tooth, including necessary anaesthetic and postoperative treatment not to exceed  | \$1.50 |
| b. Each additional tooth extracted from the same patient, not necessarily extracted at the same visit  | 1.00   |
| c. All gold crowns and bridge work removed by a dentist authorized to extract teeth, shall be given to the patient in return for a signed receipt, which shall be attached by the dentist to the voucher, when he submits his claim for performing such authorized extraction. |        |

#### ITEM 3. Fillings

Including an approved method of pulp protection, and subject to the requirements and restrictions herein shall be reimbursable at charges not to exceed the following:

- |   |      |
|---|------|
| a. Silver amalgam meeting specifications approved by the American Dental Association: one surface, not to exceed  | 2.00 |
| Two or more surfaces not to exceed  | 3.00 |
| b. Silicious cement meeting specifications approved by the American Dental Association (restricted to fillings in anterior teeth only,) not to exceed   | 3.00 |
| c. Other cements, meeting specifications approved by the American Dental Association, restricted to conditions for which a temporary filling is indicated for a permanent tooth not to exceed | 1.00 |
| Temporary tooth, not to exceed  | 50.  |

#### ITEM 4. Treatment

- |   |      |
|---|------|
| a. At a rate per visit not to exceed<br>(Same rate applied to cementing inlays, crowns and bridges) | 1.00 |
|---|------|

### ITEM 5. Dental Prophylaxis

(Note: Prophylaxis for purely esthetic reasons shall not be eligible for reimbursement)

### ITEM 6. Dental x-ray examinations

For diagnosis only and subject to other restrictions of this Manual shall be eligible for reimbursement at a rate not to exceed:

- |  |        |
|--|--------|
| a. Single film   | \$ .50 |
| b. Each additional film for the same patient, not necessarily taken at the same visit, up to and including the tenth | .25    |
| c. Full mouth x-ray series, not less than eleven films   | 3.00   |
| d. Jaw only when taken by a recognized dental surgeon  | 3.50   |

### ITEM 7. Special Dental Services

Authorized only on an individual basis, and subject to the restrictions herein shall be reimbursable at charges not to exceed the following:

- |   |       |
|---|-------|
| a. Root canal therapy only for key tooth<br>(Not recommended when more than one root canal in same tooth needs treatment)   | 5.00  |
| b. Dental surgery, other than simple extractions to include such necessary operative procedures as removal of cysts, impacted teeth and/or infected areas from                                  | 5.00  |
| c. to<br>for each operative procedure depending upon the time spent and the skill required, and including anaesthesia unless a physician or another dentist is authorized to give the services. | 10.00 |
| d. Reduction and fixation of a fracture of the jaw, at a rate not to exceed   |       |
| (1) for maxilla upper, to include 21 days after care  | 15.00 |
| (2) for mandible lower, to include 21 days after care   | 25.00 |

### ITEM 8. Repairs of Dental Prosthetic Devices

The repairs of dental prosthetic devices including the repairs of: vulcanite dentures; crowns and inlays; and bridges shall be subject to the requirements herein, and shall be reimbursable not to exceed

- |  |        |
|--|--------|
| a. Dentures  |        |
| (1) Vulcanizing charge including repair of all cracks, fissures and/or fractures; replacement of one or more teeth; and attaching by vulcanization one or more clasps—in any one vulcanite denture | \$3.00 |
| (2) Additional charge for first tooth replaced in such a vulcanite denture   | 1.00   |



- |     |  |      |
|-----|--|------|
| (3) | Additional charge for each additional tooth, after the first, replaced in any such vulcanite denture   | .50  |
| (4) | Additional charge for making and fitting a clasp only in cases where a new clasp is required, to replace a broken clasp or to change the point of retention due to loss of key tooth, to insure accurate fit of any such such vulcanite denture  | 4.00 |
|     | Provided that only 18.3 carat gold shall be used in making clasps, and provided further, that all clasps removed by the dentist and/or laboratory technician shall be given to the patient in return for a signed receipt, which shall be submitted with the voucher for making and fitting a clasp. |      |
| (b) | Crowns and inlays  |      |
|     | (1) Recementing  | 1.00 |
|     | Bridges  |      |
|     | (1) Recementing  | 2.00 |

#### ITEM 9. Dentures, Inlays, Crowns and Bridges

Expenditures for dentures, crowns and bridges are reimbursable only when claim is supported by physician's statement of disability to be corrected by use of dentures or other dental appliances plus case worker's opinion as to likelihood that patient will learn to use them with ease and other socio-medical factors, having a bearing on the situation, such as age, previous use of dentures, et cetera, subject to the above restrictions, reimbursement will be granted at not to exceed:

- |     |   |        |
|-----|---|--------|
| a.  | Dentures  |        |
| (1) | Full upper vulcanite denture not to exceed  | 30.00  |
| (2) | Full lower vulcanite denture not to exceed  | 25.00  |
| (3) | Set of full vulcanite dentures not to exceed  | 55.00  |
| (4) | Partial upper vulcanite, not to exceed  | 25.00  |
|     | plus  | 4.00   |
|     | for each clasp  |        |
| (5) | Lower lingual bar (16 carat gold) to be used where anterior teeth are in position, not to exceed with clasp (18.3 carat gold) plus for each clasp | 4.00   |
|     | Note: Partial restorations are recommended where 60 percent of the efficiency is destroyed, or where anterior teeth are missing)                  |        |
| b.  | Inlays, Gold, Anterior teeth  |        |
| (1) | Incisal cavities, not to exceed   | \$6.00 |
| (2) | Messio or disto-incisal cavities, not to exceed   | 9.00   |
| (3) | Mesio-incisal cavities, not to exceed   | 15.00  |
| c.  | Inlays, Gold, Posterior teeth   |        |
| (1) | Two tooth surfaces not to exceed  | 12.00  |

	(2) Three or more tooth surfaces, not to exceed	18.00
d.	Crowns	
	(1) Case base, porcelain crown, not to exceed	15.00
	(2) Porcelain faced, gold back, either cast or swayed and soldered, with or without band band or coping around the neck of the root, not to exceed	18.00
	(3) Gold crown, two piece with heavy case cusps, or all cast, not to exceed	15.00
	(4) Gold crown, three-quarter, tinker or Car-michael, not to exceed	20.00
e.	Bridges	
	(1) Gold crowns (see item 9 d (3) (4)	
	(2) Gold inlays (see item 9 b and c)	
	(3) Pontics or dummies, all gold, posterior, not to exceed	7.50
	(4) Pontics or dummies, gold and porcelain, not to exceed	9.00

#### ITEM 10. Maximum Expenditures for Dentistry

Any reimbursable dental care provided for any one person in one calendar year in excess of \$30.00 shall require specific and prior approval of Medical Consultant.

# Central Medical Unit

## *Welfare Office Procedures*

Under the general direction of the Commissioner of Public Welfare and the Board of Child Welfare, fulfill authority for the administration of the medical program and the authorization of medical care has been delegated to the Central Medical Unit. By means of a Daily Transmittal Sheet Form M-15, the Case Supervisor and Social Service Staffs shall be informed of all medical care authorized. Dates of discharge from hospital of individual patients shall also be shown on the Daily Transmittal Sheet.

## **II Personnel**

A. One part-time Medical Consultant to serve all welfare units within the County (except the City of Schenectady) and the Board of Child Welfare.

B. One full time Medical Clerk, County Welfare Office.

C. Senior Investigator, Board of Child Welfare.

D. Children's Agent, Child Welfare

E. Towns as follows: Glenville—the Office Manager

Niskayuna—the Investigator

Princtown—the Town Supervisor

Duanesburg—the Town Welfare Officer

Rotterdam—the Office Manger

F. Accounting assistance in each of the above mentioned offices sufficient to maintain accounting procedures and records in conformity with the requirements of the State Department of Social Welfare and local fiscal regulations.

## **III Duties**

### **A. MEDICAL CONSULTANT**

1. The Medical Consultant is responsible for the administration of the medical program. He shall review all requests for medical care, and grant prior and/or specific approval on all items for which such approval is required, as indicated on pages 4-5 of this manual. He shall indicate approval or disapproval by signing the individual item on the Individual Patient's Medical Record Form M-4.

2. Shall follow up on patients in hospital relative to discharge and where indicated, advise social service staffs as to plans and necessary after care.

3. Shall be available for discussion of medical problems with the Commissioner of Public Welfare, the Board of Child Welfare, the Children's Agent, the Case Supervisor and through the latter, members of the Social Service Staff, the Town Welfare Representatives, and any physician or vendor concerned with the medical program.

4 Shall be responsible for determining medical need for patients not in receipt of public assistance.

### **B. MEDICAL CLERK**

1. The Medical Clerk shall be responsible for the mechanics and procedures relevant to the administration of the medical program.



2. She shall receive from the Commissioner's Office all incoming medical mail after it has been stamped with the date of receipt. She shall distribute the Board of Child Welfare and Child Welfare mail and hold mail pertaining to settled Town cases, for review by the Medical Consultant.

3. She shall present the Individual Patient's Medical Record Card Form M-4 together with each medical request which is to be reviewed by the Medical Consultant.

4. After the review she shall redistribute the requests to the agency which is responsible for granting assistance to the patient and shall in addition inform the Town Welfare Representatives of all approvals granted or denied so that they may issue authorization.

## *IV Procedure*

### **A. AUTHORIZATION**

1. Authorization is limited to not more than 10 visits in a calendar month on one authorization.

2. The patient shall go directly to the physician of his choice.

3. The physician shall within 48 hours (Sundays and legal holidays excepted) of the patient's first call forward the official physician's notification card, Form M-1.

4. The Medical Clerk, Senior Investigator of Board of Child Welfare and/or Children's Agent shall check the card Form M-1 for:

(a) 48 hour mailing period.

(b) Eligibility status of the patient.

(c) The Children's Agent shall O. K. the card if she approves the requested care, before returning it to the Medical Clerk, thus authorizing issuance of a Form PA-210M to the physician.

5. If the patient is not in receipt of assistance the Notification Card Form M-1 shall be referred for investigation as to eligibility. The physician shall promptly be informed, either that the case is pending investigation, or that it is not accepted by the welfare agency, by forwarding Form M-13.

6. On active and accepted cases, the Medical Clerk or Senior Investigator of Board of Child Welfare, shall pull the Patient's Individual Medical Record Card Form M-4 attach to it the Physician's Notification Card Form M-1 and give both to the Medical Consultant for review.

7. If the Medical Consultant has any question in regard to the physician's request, he shall communicate with the physician, and note on the Form M-1, the agreed upon number of visits.

8. The Medical Consultant shall approve the request by signing the Individual Patient's Medical Record Card Form M-4.

9. After written approval by the Medical Consultant, Forms PA-210M shall be issued as follows:

a) By the Medical Clerk for Old Age Assistance, Aid to the Blind, Child Welfare and non-settled home relief. The Medical Clerk shall write the Form PA-210M for settled home relief, but shall forward it to the Town Representative for authorization signature and forwarding to the physician.

b) By the Senior Investigator for Board of Child Welfare Cases.

**B. REAUTHORIZATION**

If more than the first 10 authorized visits are needed, the physician shall forward a new Physician's Notification Card Form M-1 indicating the reason for the additional calls. On receipt of the card procedure is the same as described above Item IV A-9.

**C. DRUGS**

1. Drugs shall be authorized only on written prescription for the individual patient and shall be restricted to official drugs as listed in the United States Pharmacopoeia, the National Formulary or the list of proprietary drugs accepted by the State for reimbursement. (See list page 16.)

2. The patient shall take the prescription to the drugstore and the pharmacist shall within 48 hours (Sundays and legal holidays excepted) return to the Medical Unit in the County Welfare Department, the original prescription showing the prescription number, the date prescription was filled, the cost and the signature of the person receiving the drug. (If the recipient is not the patient himself there shall also appear the agent's relationship to the patient.)

Note:—In case of narcotic prescriptions, the druggist shall return two copies of the prescription clearly marked across the face "Narcotics" No To Be Refilled.

3. (a) On receipt of the prescription from the druggist, the procedure to be followed is the same as for physicians. Items IVA, 4, 5, 6, 7 and 8 and page 39.

(b) The authorizing signature of the Medical Clerk shall appear on prescriptions for Old Age Assistance, Aid to the Blind, Child Welfare and non-settled home relief. The signature of the Senior Investigator shall appear on prescriptions for Board of Child Welfare, while the Town home relief prescriptions shall be forwarded to the Town Welfare Representative for signature and filing. On Town Home Relief prescriptions the Medical Clerk shall indicate the Medical Consultant's approval or disapproval.

4. If the prescription was mailed within the 48 hour period and physician's care has been authorized, the Medical Clerk shall enter on the Patient's Individual Medical Record Card Form M-4 the date the prescription was issued, prescription number and the cost. The Medical Consultant's signature shall appear on the Patient's Individual Medical Record Card Form M-4.

5. Prescriptions attached to the Vendor's vouchers to which they relate shall then be filed according to druggists and in numerical sequence by the prescription number.

6. At the end of the month, after the bills have been paid, the prescriptions shall be filed in a permanent file set up as described above.

**D. DENTAL CARE**

1. Patients in need of dental care shall go to the dentist of their choice. During the first visit, only diagnostic or emergency care may be given.

Note: In exceptional cases, in which the dentist finds it necessary to give more than emergency or diagnostic care during the first visit, he shall first secure verbal authorization, by telephone from the Medical Clerk. Authorization may be given only if the cost of the care is within the fee schedule

and the total cost within \$30.00. Such verbal authorization shall be followed by the submission of the dental card Form M-2 within 48 hours (Sundays and legal holidays excepted) of the patient's visit.

2. Within 48 hours (Sundays and legal holidays excepted) of the patient's first visit, the dentist shall mail the official Dentist's Notification Card Form M-2 to the Central Medical Unit in the County Welfare Office. The Form M-2 shall indicate the emergency care given and the cost thereof. If further care is needed the dentist shall so indicate on the Dental Chart and shall also show the materials to be used and the cost of each unit of dental care.

3. The Medical Clerk, Senior Investigator for Board of Child Welfare and/or Children's Agent for Child Welfare shall check the Form M-2 for:

(a) 48 hour mailing period and eligibility status of the patient.

(b) The Children's Agent shall O. K. the card if she approves the requested care, before returning it to the Medical Clerk, thus authorizing issuance of a PA-210M to the dentist.

(c) If a patient is not in receipt of public assistance the Medical Clerk shall immediately notify the dentist that the case is either, pending investigation or that it is not accepted by the Welfare Agency, by form M-13.

On active and accepted cases the Medical Clerk shall pull the Patient's Individual Medical Record Card Form M-4, attach it to the Dental Form M-2 and give both to the Medical Consultant for review.

Note: If the Medical Consultant has any question in regard to the dental request he shall refer it to the representative of the Dental Profession on the Medical Advisory Committee. The latter shall communicate with the dentist and on the basis of their decision, shall note and sign on the Form M-2 the agreed upon dental care. The card shall be returned to the Medical Clerk in the County Welfare Office and authorization issued on Form PA-210-M for the approved dental care. See Item IV-A-9 page 39.

Note: In Town Cases the Medical Consultant's approval shall appear on the Form M-4 but shall be indicated on the Form M-2 by Medical Clerk, and in all other cases on the Patient's Individual Medical Record Card Form M-4.

## E. DENTURES

1. Request for dentures is to be supported by a written statement from the attending physician giving reasons why dentures are necessary.

2. The request in addition to being reviewed by the Medical Consultant is to be reviewed by Case Supervisor, Children's Agent or Senior Investigator of Board of Child Welfare for information to the Medical Consultant as to the patient's ability and willingness to use dentures, as well as possibility of patient's employment and any other medical-social factors. Authorization to be on Form PA-210-M as described above.

## F. HOSPITAL CARE

### I. AMBULATORY PATIENTS

(a) Except in medical or surgical emergency, the patient shall be referred by his physician to the appropriate clinic at Ellis Hospital for examination and



decision regarding hospitalization. The hospital shall forward Form M-5 to the Medical Clerk in the Central Medical Unit, in the County Welfare Office.

(b) On receipt of Form M-5 the Medical Clerk shall clear the request for eligibility, and if the patient is not in receipt of assistance, the request shall be referred for investigation.

(c) All requests for hospitalization shall be referred to the Medical Consultant together with the Patient's Individual Medical Record Card Form M-4 for his review and approval, which shall appear on the Patient's Individual Medical Record Card Form M-4.

(d) When hospitalization has been approved or disapproved by the Medical Consultant both the patient and the attending physician shall be notified, by forwarding of Form M-13.

## II. BED PATIENTS

(a) The physician, except in medical or surgical emergency, shall notify the Medical Clerk in the County Welfare Office by forwarding the Physician's Notification card Form M-1 indicating that hospitalization is recommended.

(b) Board of Child Welfare and Children's Agent after clearing the case shall transmit the requests to the Medical Clerk for authorization. The Medical Clerk shall make arrangements with the hospital for admission of the patient after review and approval by the Medical Consultant (indicated on Patient's Individual Medical Record Card Form M-4.) She shall also notify the patient or his family of the arrangements she has made, and the physician of the approval or disapproval of the request.

(c) In medical or surgical emergency necessitating immediate hospitalization, the physician may send the patient directly to the hospital, but shall, within 48 hours (Sundays and legal holidays excepted) follow the procedure outlined in Item II-a above.

(d) Authorization—on receipt from the hospital of a Notice of Admission to Hospital, Form M-6, the Medical Clerk shall issue authorization of Hospital Care on Form M-7, authorizing care for the period approved by the Medical Consultant. Form M-7 shall be issued to the hospital in duplicate and the third copy shall be retained in the Welfare Office.

(e) On receipt of the Notice of Discharge, Form M-8 the Medical Clerk shall match the Notice of Admission and Notice of Discharge forms and hold them until receipt of one copy of the authorization Form M-7.

### (f) Extension of Hospital Care

1. If a patient needs hospital care for a period longer than that originally authorized, on receipt of a new Notice of Admission from the hospital Form M-6 the procedure is the same as noted above, with a new Hospital Authorization Form M-7 issued for the extended period of time approved by the Medical Consultant.

## III SPECIAL SERVICES IN HOSPITAL

Individual authorization shall be issued on Form M-7 if approved by the Medical Consultant, for all services for which a charge is made over the daily rate. (See specific sections in this manual for x-ray, deep therapy, special nursing, etc.)

## G. EYE EXAMINATIONS AND EYE GLASSES

### I *By ophthalmologists, outside of Ellis Clinic.*

- (a) Restricted to classifying examination for Assistance to the Blind.
- (b) Specific cases in which clinic cannot be used, if there has been prior approval by the Medical Consultant.
- (c) Authorization procedure same as for general physicians.

### II *By Optometrists*

- (a) Shall be authorized only on written recommendation of patient's attending physician.
- (b) Authorization shall be issued on Form PA-210-M for glasses only. (No fees shall be paid to optometrist for refraction.)

III Specific approval of the Medical Consultant is required on all glasses. The approval and signature of the Medical Consultant shall appear on the Patient's Individual Medical Record Card Form M-4.

IV The prescription for glasses shall be shown on Form PA-210M, which shall be attached to the County Voucher.

## H. NURSING OR BEDSIDE CARE

### I *In the home*

- (a) On receipt from a physician of Form M-3, this together with the Patient's Individual Record Card Form M-4, shall be referred to the Medical Consultant for his review and approval or disapproval.
- (b) If approved, authorization shall be issued on Form PA-210M for the period designated by the Medical Consultant. *Note:* Nursing care may be approved for a maximum of three months at a time.

(c) Extension of nursing care is authorized in the same way as the original request for nursing care after receipt of a new Form M-3 from the attending physician and with the approval of the Medical Consultant. In cases where there is long continued nursing care, the case shall be reviewed by the Medical Consultant with the Case Supervisor or Senior Investigator of the Board of Child Welfare and/or Children's Agent, in order that social factors may be evaluated and the possibility of a plan other than continuous nursing care in the home be considered.

(d) In medical or surgical emergencies, the physician may make his request for nursing care by telephone but shall submit Form M-3 within 48 hours (Sundays and legal holidays excepted) of his telephone call.

### II *In the hospital*

- (a) See limitations page 19.
- (b) Procedure for authorization is the same as for nursing care in the home except that authorization shall be given on Hospital Authorization Form M-7.

### III *Care in Nursing Home*

(a) The need for care in a nursing home as differentiated from board and care shall be determined by the patient's specific medical or nursing needs, as recommended by submission of Form M-3 by the attending physician. (See Item G-2—pages 9-10.)

(b) Requests for placement in Nursing Homes are subject to review by the Medical Consultant and Case Supervisor, Senior Investigator for the Board of Child Welfare, Children's Agent for Child Welfare, and must have the specific approval of the Medical Consultant.

(c) Cases approved by the Medical Consultant, shall be referred to the Case Work Division, or the Senior Investigator for Board of Child Welfare, or Children's Agent for Child Welfare, for authorization.

## **I. OBSTETRICAL CARE**

### *I Home Delivery*

(a) One authorization Form PA-210M to cover prenatal visits up to a maximum of 10, and

(b) One authorization Form PA-210M for home delivery and post-partum care, including the final gynecological examination.

(c) Information or reports received from the Public Health Nurses in attendance at home delivery, after review by the Medical Consultant, shall be sent to the Case Supervisor, or Senior Investigator, for Board of Child Welfare for filing in the case record.

### *II Hospital Delivery*

(a) One authorization Form PA-210M to cover the number of prenatal visits made before patient is referred either to clinic or to the hospital. (Maximum prenatal visits 10.)

(b) Authorization for delivery in the hospital is the same as for any hospitalization. Use Hospital Authorization Form M-7.

## **J. ORTHOPEDIC AND PROSTHETIC APPLIANCES**

I. Recommendations for orthopedic appliances before being referred to the Medical Consultant for approval, shall be reviewed and written recommendations made by an orthopedic specialist or a surgeon with S. A., S. B. or S. C. rating. The orthopedist's or surgeon's recommendation shall be reviewed by the Medical Consultant as part of the basic information on which his decision is based for approval or disapproval.

*Notes Orthopedic appliances costing over \$10.00 for persons up to 21 years of age are the responsibility of the Children's Court and shall not be supplied by the welfare department.*

II. All prosthetic appliances costing over \$10.00 shall be reviewed for specific prior approval by the Medical Consultant before authorization is issued.

III Authorization shall be issued on Form PA-210M on Individual prescription for each patient.

## **K. PREPLACEMENT EXAMINATION FOR CHILD WELFARE**

I Authorization shall be issued as for any office visit, by use of Form PA-210M. The physician's report shall be made on Form C. W.-17.

## **L. PHYSICAL EXAMINATION FOR EMPLOYABILITY AND ELIGIBILITY FOR BOARD OF CHILD WELFARE**

1. Authorization shall be issued as for any office visit, by use of Form PA-210-M. The physician's report shall be made on Form M-14.

## **M. PHYSIOTHERAPY**

1. Authorization is issued by same procedure as for physicians—see Item



IV--A, page 39, after the request has been reviewed and approved by the Medical Consultant.

2. Authorization to hospital for out-patients shall be made in same way except that Hospital Authorization Form M-7 shall be used.

## **N. RADIUM**

1. All requests for radium treatment shall have the specific prior approval of the Medical Consultant.

2. Requests shall be submitted on Form M-12.

3. Authorization is the same as to physicians, see Item IV-A, page 39.

## **O. SICK-ROOM SUPPLIES**

See drug item III-D, page 15. Supplies costing over \$5.00 shall have the specific prior approval of the Medical Consultant.

## **P. SPECIALISTS' SERVICES**

1. Services of a specialist either on a consultative basis or treatment basis, shall be authorized only when such services are not available through the Ellis Hospital Clinic, or when the patient is physically unable to attend clinic.

2. Treatment by a private specialist shall be recommended by the attending physician by submission of Form M-1 and shall have the specific approval of the Medical Consultant.

3. Authorization is the same as to physicians see Item IV-A, page 39.

Note: Exception: referral to an ophthalmologist for A. B. classifying examination.

## **Q. SPECIAL DIETS**

1. Recommendations from physicians for special diets shall have review and specific approval of the Medical Consultant, which shall be recorded on Form M-4.

## **R. X-RAY**

1. DIAGNOSTIC—exclusive of in-hospital patients.

a. Except in medical or surgical emergency request for diagnostic x-rays shall have the prior specific approval of the Medical Consultant before authorization is issued.

b. Request for such approval shall be submitted on Form M-10.

c. In medical or surgical emergency, physicians or hospital may request authorization by telephone but shall submit Form M-10 within 48 hours (Sundays and legal holidays excepted) of the telephone request.

d. Authorization same as for physicians—see Item IV-A, page 39. Authorization to hospital on Hospital Form M-7.

## **II. X-RAY THERAPY**

a. All x-ray treatment shall have the specific prior approval of the Medical Consultant.

b. Requests shall be submitted on Form M-11.

c. Authorization procedure is the same as described for diagnostic x-ray Item R-I, above.

## **III. RECORDING AND FILING**

1. All authorized medical care, hospital care, supplies or services shall be recorded on the Patient's Individual Record Card Form M-4, by the Medical Clerk at the time of authorization. This file maintained by the Medical Clerk shall be in alphabetical order by patient's name.

2. All approvals by the Medical Consultant shall be recorded on the Individual Patient's Record Card Form M-4. In settled Town cases the Medical Clerk shall note the approval on Form M-1 and/or Form M-2 as well as on RX blanks and sign her initials.

3. The Medical Clerk shall maintain the Daily Transmittal Sheet Form M-15 sending a copy to the Case Supervisor, Board of Child Welfare, Senior Investigator, Children's Agent, each Town Welfare Officer and the Commissioner of Public Welfare daily. The Case Supervisor shall be responsible for circulating the Daily Transmittal Sheet to the members of her Social-Service Staff so that they have prompt information of medical care authorized. Dates of discharge from hospital shall also be shown on the Daily Transmittal Sheet.

4. Office copies of all authorization forms shall be filed by month, by name of vendor, pending receipt of bills. After the bills have been paid, the authorization forms shall be filed in the accounting division as follows:

*Indirect* payments, in individual folder for each medical vendor, with the office copy of the vendor's voucher attached.

*Direct* payment, by month in numerical sequence of special authorization number.

#### IV. PREPARATION AND SUBMISSION OF BILLS

##### A. Medical Services and Supplies.

1. By the seventh of the month following that in which medical care was given, the physicians, dentists, and nurses shall return two copies of Form PA-210-M, and hospitals, 1 copy of Form M-7.

2. The Medical Clerk, on receipt of the Forms PA-210-M shall audit them against the office copy of the Form PA-210-M, the fee schedule and for mathematical accuracy.

3. On Forms PA-210-M's to be paid by direct method, the Medical Clerk shall insert the special authorization number on the face of the form.

4. Prepare County Voucher which should be returned to vendors for signature and affidavit. (Indirect payment only.)

5. The Medical Clerk shall then post the costs to the Individual Patient Record Card Form M-4.

6. All Forms PA-210-M and County vouchers shall then be transmitted to the accounting division.

#### V. ACCOUNTING PROCEDURES

*The accounting division shall be responsible for:*

1. Preparation of direct and indirect payment rolls.

2. Preparation and mailing of notices to recipients and special checks to patients.

3. Preparation and submission of claims for reimbursement and chargeback bills on reimbursable items for OOA, AB, and BCW to the State Department of Social Welfare.

4. Preparation of chargeback bills for all H. R. items and non-reimbursable items to the chargeback district.

5. Posting of all medical costs to Forms PA-21 and Vendor's Cost Card.

*NOTE: All checks are prepared by the County Auditor and Treasurer. Checks for indirect payment are distributed by the County Treasurer, together with the Vendor's Copy of the county Voucher.*

# REIMBURSABLE CHARGES PER PAIR FOR EYEGLASSES

(With Case), Complete with First Quality White Lenses\* and Frames\*  
Fitted and Adjusted

Less Strength in Diopters		SINGLE VISION BIFOCALS Toric flat or Meniscus lenses	Lenses with fused bifocal segments up to 4.50 D
SPHERES		+ or —	+ or —
Plane	to 2.00 .....	\$4.20	\$6.40
2.25	to 4.00 .....	4.50	7.00
4.25	to 6.00 .....	4.75	7.60
6.25	to 9.00 .....	4.90	8.20
9.25	to 20.00 .....	6.35	9.65
PLANE CYLINDERS		+ or —	— only
0.12 to 2.00 Cyl.	.....	\$4.65	\$7.00
2.25 to 3.00 Cyl.	.....	4.85	7.30
3.25 to 4.00 Cyl.	.....	5.05	7.60
4.25 to 6.00 Cyl.	.....	5.75	8.20
SPHERO CYLINDERS		+ = +	— = +
0.12	( 0.12 to 2.00 Cyl.....	\$4.65	\$4.95
to=	( 2.25 to 3.00 Cyl.....	4.85	5.15
2.00	( 3.25 to 4.00 Cyl.....	5.05	5.35
Sph.	( 4.25 to 6.00 Cyl.....	5.75	6.05
2.25	( 0.12 to 2.00 Cyl.....	5.05	5.35
to=	( 2.25 to 3.00 Cyl.....	5.35	5.65
4.00	( 3.25 to 4.00 Cyl.....	5.65	5.95
Sph.	( 4.25 to 6.00 Cyl.....	6.35	6.65
4.25	( 0.12 to 2.00 Cyl.....	5.55	5.85
to=	( 2.25 to 3.00 Cyl.....	5.75	6.05
6.00	( 3.25 to 4.00 Cyl.....	6.45	6.75
Sph.	( 4.25 to 6.00 Cyl.....	7.05	7.35
6.25	( 0.12 to 2.00 Cyl.....	6.30	6.60
to=	( 2.25 to 3.00 Cyl.....	6.45	6.75
9.00	( 3.25 to 4.00 Cyl.....	7.05	7.35
Sph.	( 4.25 to 6.00 Cyl.....	7.65	7.95
9.25	( 0.12 to 2.00 Cyl.....	7.50	7.80
to=	( 2.25 to 3.00 Cyl.....	7.65	7.95
20.00	( 3.25 to 4.00 Cyl.....	8.25	8.55
Sph.	( 4.25 to 6.00 Cyl.....	8.85	9.15

\* Bausch and Lomb, "Balcor", or American Optical Company, "Centex", standards, or their equivalent, for single vision lenses and "Kryptok" for bifocal lenses,



i. e. meeting standard specifications, and without obvious imperfection or defect — such as chip, bubble or scratch. For prism values combined with lenses, add to price of complete eyeglasses \$1.50. For replacement of lenses:  $\frac{1}{2}$  pair at 40 per cent, 1 pair at 70 per cent of charges listed above. For the maximum reimbursable basis for eyeglasses with lens combinations or strengths other than those listed, refer optical prescription by letter to the Department of Social Welfare, Division of Medical Care, for specific written approval before purchase.

\*\* Frames shall be of white metal, pad bridge, or its equivalent, and of U. S. A. manufacture. Repairs to frames: one temple \$.50; pair temples \$1.00; front \$1.00; all fitted and adjusted. For replacement of complete frame \$1.50 including fitting and adjustment.

# **FORMULA FOR REIMBURSABLE CHARGES\* FOR DRUGS DISPENSED TO ELIGIBLE RECIPIENTS OF PUBLIC ASSISTANCE**

## **I. CHARGES FOR \*\*UNCOMPOUNDED PRESCRIPTIONS**

- a. When wholesale cost of drugs and container is \$1.00 or less, ADD 50%—acceptable minimum charge is \$0.25
- b. When wholesale cost of drugs and container is more than \$1.00, ADD 30%—acceptable minimum charge is \$1.50

## **II. CHARGES FOR \*\*\*COMPOUNDED PRESCRIPTIONS**

Wholesale cost of drugs and container PLUS 30% and PLUS compounding service charge listed below—acceptable minimum charge is \$0.35.

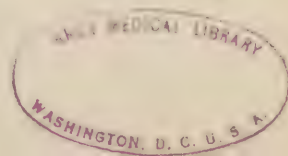
### **COMPOUNDING SERVICE CHARGES**

Liquid Prescriptions			Dry Mixtures (pills, powders, capsules, wafers)			Bulk Powders			Ointment and Cerates			Bougies, etc. Suppositories,		
Volume	Charge		Number	Charge		Weight	Charge		Volume	Charge		Number	Charge	
1/2 oz.	\$ .15		4	\$ .15		1 oz.	\$ .20		1/2 oz.	\$ .20		1	\$ .20	
1 oz.	.20		6	.20		2 oz.	.30		1 oz.	.25		2	.30	
2 oz.	.25		8	.25		3 oz.	.35		2 oz.	.35		3	.35	
3 oz.	.30		10	.30		4 oz.	.40		3 oz.	.45		4	.40	
4 oz.	.35		12	.35		6 oz.	.45		4 oz.	.55		5	.45	
6 oz.	.40		15	.40		8 oz.	.50		6 oz.	.65		6	.50	
8 oz.	.45		20	.45		12 oz.	.55		8 oz.	.75		8	.60	
12 oz.	.50		24	.50		16 oz.	.65		16 oz.	1.00		10	.65	
16 oz.	.60		30	.60		20 oz.	.75					12	.75	
32 oz.	.75		40	.75		24 oz.	.85					15	.90	
			50	.90		32 oz.	.95					18	1.05	
			75	1.15								21	1.20	
			100	1.40								24	1.35	
			(Each 25									30	1.60	
			over 100)	.20										

\* See Item III — Pages 15-16.

\*\* Defined as prescriptions for U.S.P., N.F. or drugs on State-Approved List of Non-Official Preparations requiring no mixing by dispensing pharmacist, i. e., requiring (1) merely a transfer of a medicament from one container to another, or (2) mixing one medicament with a simple base, e. g., water.

\*\*\* Defined as prescriptions in which two or more pharmaceutically active ingredients (U.S.P., N.F. or on State-Approved List of Non-Official proprietary Preparations) are mixed by the dispensing pharmacists in or with a simple base.







## CONFIDENTIAL INFORMATION

### X-ray Fee for Recognized Specialist

#### Diagnostic X-ray (Exclusive of hospital)

Single finger	3.50
Single toe	3.50
Hand (including fingers)	5.50
Wrist (including carpus and lower 1/3 of forearm)	5.50
Forearm (mid one-third)	5.50
Elbow (including upper 1/3 of forearm and supra-condyles)	5.50
Humerus (mid one-third)	5.50
Foot (including toes)	5.50
Ankle (including lower three inches of leg)	5.50
Leg (mid one-third)	5.50
Knee (including four inches above and below joint)	5.50
Femur (mid one-third)	5.50
Femur (upper one-third)	5.50
Shoulder joint	6.75
Clavical	6.75
Scapula	6.75
Hip Joint	10.00
Head and face (complete examination)	13.50
Head and face, partial examination for follow up when area of injury has been demonstrated previously	6.75
Nasal bones	6.75
Nasal sinuses	10.00
Mastoids	10.00
Mandible, one side	6.75
Cervical spine	10.00
Dorsal spine	10.00
Lumbar spine	10.00
Pelvis	10.00
Sacro-iliac joint and coccyx	10.00
Any two spinal regions	16.75
Any three spinal regions	23.50



# INDEX TO FORMS

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18	Forms PA-210-M
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DEPARTMENT OF PUBLIC WELFARE  
COURT HOUSE, SCHENECTADY, N. Y.

PHYSICIAN'S REQUEST FOR AUTHORIZATION

This card must be filled in and mailed to the above-named office immediately after your first call on a patient; if postmarked later than 48 hours after your first call, (Excepting Sundays and legal holidays) you may not be compensated for the visit.

Unless notified otherwise you will be sent an authorization for the number of calls you indicate below; if additional visits become necessary, another card must be submitted if payment for your services is expected.

LEO H. VOSBURG  
COMMISSIONER OF PUBLIC WELFARE

Head of Family: \_\_\_\_\_  
Address: \_\_\_\_\_  
Name of Patient: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Prognosis: \_\_\_\_\_  
Date of First Visit \_\_\_\_\_  
Estimated Additional Visits Necessary: Home \_\_\_\_\_ Office \_\_\_\_\_  
Frequency of Visits: Daily \_\_\_\_\_  
Weekly \_\_\_\_\_  
Semi-monthly \_\_\_\_\_  
Monthly \_\_\_\_\_

Category \_\_\_\_\_ | C.W. \_\_\_\_\_  
Case Number: \_\_\_\_\_  
For Welfare Dept. use: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Address \_\_\_\_\_ Date \_\_\_\_\_  
Form M-1

DEPARTMENT OF PUBLIC WELFARE  
COURT HOUSE, SCHENECTADY, N. Y.  
DENTIST'S REQUEST FOR AUTHORIZATION

Dental  
Chart

1. Kindly indicate emergency service rendered, on \_\_\_\_\_ date \_\_\_\_\_
2. Indicate on chart further necessary dental care.
3. Itemize cost and material used.

Code:—Extractions — (X)  
Fillings — (O)

Head of Family \_\_\_\_\_  
Address \_\_\_\_\_

For D. P. W. Use only  
Category \_\_\_\_\_ | C.W. \_\_\_\_\_  
Case No. \_\_\_\_\_  
Order No. \_\_\_\_\_

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ Address \_\_\_\_\_ Date \_\_\_\_\_  
Authorized by \_\_\_\_\_ Title \_\_\_\_\_  
Form M-2

DEPARTMENT OF PUBLIC WELFARE  
COURT HOUSE, SCHENECTADY, N. Y.  
REQUEST FOR AUTHORIZATION OF NURSING CARE

Name of Patient \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

For D. P. W. use only.	
Category _____	C.W. _____
Case No. _____	
Order No. _____	

Complete Diagnosis Recommendation and Reasons Necessitating Care:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

In own home ☐

In Nursing or Convalescent Home ☐

Registered Nurse \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_

Licensed Practical Nurse \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_

No. of Weeks \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

INFORMATION FROM SOCIAL SERVICE

Family Members— Age Why cannot a family member give necessary

1. \_\_\_\_\_ care? \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cost per day \_\_\_\_\_

Cost per week \_\_\_\_\_

Cost per month \_\_\_\_\_

SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_





RECOMMENDATION FOR HOSPITAL CARE

Case No. _____
Category _____   C.W. _____
For D.P.W. use only

Name of Patient \_\_\_\_\_ Address \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Is in need of Hospital Care for: \_\_\_\_\_

TENTATIVE DIAGNOSIS: \_\_\_\_\_

Approximate period of hospitalization \_\_\_\_\_

Date \_\_\_\_\_

Signature of Physician \_\_\_\_\_

APPROVED ☐

DISAPPROVED ☐ For \_\_\_\_\_ DAYS \_\_\_\_\_ WEEKS \_\_\_\_\_ MONTHS

Date \_\_\_\_\_

Signature of Medical Consultant \_\_\_\_\_

Form M-5

Hospital \_\_\_\_\_

NOTICE OF ADMISSION

NOTE: This form must be forwarded within 48 hours of patient's admission if hospital expects payment from public funds.

To: Commissioner of Public Welfare  
Schenectady County, Court House  
Schenectady, New York

FROM \_\_\_\_\_ Hospital \_\_\_\_\_ Date \_\_\_\_\_

Name of Patient \_\_\_\_\_  
(Surname) (Given Name) (Initial)

Home Address \_\_\_\_\_  
Age \_\_\_\_\_  
Sex \_\_\_\_\_  
Marital \_\_\_\_\_  
Status \_\_\_\_\_

Has patient received Public Assistance \_\_\_\_\_ Where \_\_\_\_\_ When \_\_\_\_\_

Referred to Hospital by \_\_\_\_\_

Admitted — Date \_\_\_\_\_ Time \_\_\_\_\_ AM

Admitted by \_\_\_\_\_ PM

Tentative Diagnosis \_\_\_\_\_

Estimated Period of Hospitalization \_\_\_\_\_

Admitted to Medical Service \_\_\_\_\_

Surgical Service \_\_\_\_\_

Reason necessitating immediate or emergency admission \_\_\_\_\_

Name and address of person who is to make application to  
Welfare Department \_\_\_\_\_

Signed \_\_\_\_\_

Form M-6 Title \_\_\_\_\_

SCHENECTADY COUNTY  
DEPARTMENT OF PUBLIC WELFARE  
HOSPITAL AUTHORIZATION

To the Superintendent of Hospital

The following services are hereby  
authorized for:

For D. P. W. only

Case No. \_\_\_\_\_

Category \_\_\_\_\_ C.W. \_\_\_\_\_

Order No. \_\_\_\_\_

Patient's Name _____	Age _____	Sex _____
----------------------	-----------	-----------

Address \_\_\_\_\_

Hospital Care from: \_\_\_\_\_ for a period of: \_\_\_\_\_

Ambulance — From \_\_\_\_\_ To \_\_\_\_\_

SPECIAL SERVICES WHILE IN HOSPITAL (SPECIFY)

\_\_\_\_\_

\_\_\_\_\_

OUT PATIENT AUTHORIZATION

SPECIFY SERVICE

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

APPROVED \_\_\_\_\_

DISAPPROVED \_\_\_\_\_

Medical Consultant \_\_\_\_\_

Authorized by: \_\_\_\_\_

Title

LEO H. VOSBURG  
Commissioner Public Welfare

Form M-7

NOTICE OF DISCHARGE FROM HOSPITAL

To: Commissioner of Public Welfare

From: \_\_\_\_\_ Hospital

Patient's Name _____	Address _____
----------------------	---------------

Date Admitted \_\_\_\_\_ Date Discharged \_\_\_\_\_

Number of Day's Care \_\_\_\_\_

Final Diagnosis \_\_\_\_\_

Condition on Discharge

Recommendations for follow-up:

Form M8

SCHENECTADY COUNTY DEPARTMENT OF PUBLIC WELFARE

Request for Prior Approval of Prosthetic  
Appliances (Inclusive of eyeglasses)

Patient's Name \_\_\_\_\_ Address \_\_\_\_\_ Category \_\_\_\_\_ C.W. \_\_\_\_\_ Case No. \_\_\_\_\_

Sex \_\_\_\_\_ Marital Status \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Diagnosis \_\_\_\_\_

Cause of Disability to be corrected \_\_\_\_\_

If similar appliance ever provided previously, by whom and when \_\_\_\_\_

How long has client used a similar appliance? \_\_\_\_\_

Will provision of the appliance make the client physically employable?  
Specifications for appliance (include name of manufacturer, material, parts, size, etc.) \_\_\_\_\_

Cost \_\_\_\_\_ Reimbursable basis \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Address \_\_\_\_\_

Workmen's Compensation Number and Symbol \_\_\_\_\_

Physician's Signature \_\_\_\_\_

Eyeglass Prescription Form

\_\_\_\_\_ Sphere Cylinder Axis Prism

Address \_\_\_\_\_ Distant O. D. \_\_\_\_\_

Cost \$ \_\_\_\_\_ O. S. \_\_\_\_\_

Reimbursable Basis \_\_\_\_\_ Reading O. D. \_\_\_\_\_

\_\_\_\_\_ O. S. \_\_\_\_\_

Approved \_\_\_\_\_ Date \_\_\_\_\_

Disapproved \_\_\_\_\_

Signature of Medical Consultant \_\_\_\_\_



## SCHENECTADY COUNTY DEPARTMENT OF PUBLIC WELFARE

## Request for Approval Diagnostic X-ray

Date\_\_\_\_\_

Patient's Name\_\_\_\_\_ Address\_\_\_\_\_ Category\_\_\_\_\_ C.W.\_\_\_\_\_ Case No.\_\_\_\_\_

Age\_\_\_\_\_ Sex\_\_\_\_\_ Marital Status\_\_\_\_\_

Tentative Diagnosis:\_\_\_\_\_

Reason: — brief clinical note of indication for picture:—

Anatomical Area to be x-rayed\_\_\_\_\_

(Type of Series)\_\_\_\_\_

Signature of Physician Requesting X-ray\_\_\_\_\_

Approved\_\_\_\_\_

Disapproved\_\_\_\_\_

\_\_\_\_\_  
Medical Consultant

Date\_\_\_\_\_

## Finding

Roentgenological Diagnosis with Comment:\_\_\_\_\_

X-ray Physician's Signature\_\_\_\_\_

SCHENECTADY COUNTY DEPARTMENT OF PUBLIC WELFARE  
REQUEST FOR APPROVAL OF X-RAY THERAPY

Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
Patient's Address \_\_\_\_\_ Town of \_\_\_\_\_

For D. P. W. Use	
Case No. _____	
Category _____	C.W. _____

As a basis for gathering material relative to the treatment of cancer and radiology in general, it would be most helpful if the attending physician would submit the information requested below.

1. Full diagnosis( which in the case of cancer should include the location, the name of the organ or tissue involved and the type of malignancy — as well as statement as to whether or not the diagnosis had been confirmed by a pathological specimen, together with the name of the Pathologist who made the pathological examination.) \_\_\_\_\_

If "Cancer or other malignant tumor," has it been reported in accordance with Chapter 954, Laws of 1939? Yes \_\_\_\_\_ No \_\_\_\_\_.

2. Proposals for superficial or deep x-ray treatment should contain the following information:

- a. No. of K. V.'s (kilovolts) \_\_\_\_\_
- b. No. of M. A.'s (Milliamperes) \_\_\_\_\_
- c. Distance in cm. (Centimeters) \_\_\_\_\_
- d. Filter to be used: Indicate material (copper, aluminum, thor-  
eus) as well as thickness of the filter in mm. (millimeters) \_\_\_\_\_
- e. No. of fields and location (anterior, posterior, etc.) \_\_\_\_\_
- f. No. of r's (roentgens) \_\_\_\_\_
- g. Tumor dose in r's (roentgens) \_\_\_\_\_
- h. Has x-ray machine been calibrated by a physicist?

Yes \_\_\_\_\_ No \_\_\_\_\_

i. Number of treatments to be given \_\_\_\_\_

\_\_\_\_\_  
(Physician's Signature)

\_\_\_\_\_  
Date

19

\_\_\_\_\_  
Workmen's Compensation No. and Symbol

Approved \_\_\_\_\_  
(Medical Consultant)  
Form M-11

Disapproved \_\_\_\_\_

**SCHENECTADY COUNTY DEPARTMENT OF PUBLIC WELFARE  
REQUEST FOR APPROVAL OF RADIUM THERAPY**

Public Welfare District \_\_\_\_\_ Date \_\_\_\_\_  
 Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Case No. \_\_\_\_\_  
 Address \_\_\_\_\_

As a basis for gathering material relative to the treatment of cancer and radiology in general, it would be most helpful if the attending physician would submit the information requested below.

1. Full diagnosis (which in the case of cancer should include the location, the name of the organ or tissue involved and the type of malignancy — as well as statement as to whether or not the diagnosis had been confirmed by a pathological specimen, together with the name of the Pathologist who made the pathological examination.) \_\_\_\_\_

If "Cancer or other malignant tumor," has it been reported in accordance with Chapter 954, Laws of 1939? Yes \_\_\_\_\_ No \_\_\_\_\_

2. Proposals for radium therapy should contain the following information:

- a. Amount of radium or radon in mgm. (milligrams) or mc. (millicuries) \_\_\_\_\_  
 b. Filter used: material (platinum, gold or steel) as well as the thickness of the filter in mm. (millimeters) \_\_\_\_\_  
 c. Time in mghm. (milligram hours for radium) or mch. ((millicurie hours for radon emanations) \_\_\_\_\_  
 d. No. of areas treated giving location anterior, posterior, etc.) \_\_\_\_\_  
 e. No. of treatments to be given \_\_\_\_\_

\_\_\_\_\_  
 (Physician's Signature)

\_\_\_\_\_  
 (Date)

19\_\_\_\_

Form M-12

**DEPARTMENT OF PUBLIC WELFARE  
SCHENECTADY COUNTY  
Court House, Schenectady, N. Y.  
FORM LETTER**

TO: \_\_\_\_\_

Your request dated \_\_\_\_\_ for authorization to provide  
**MEDICAL CARE** Acute \_\_\_\_\_ Chronic \_\_\_\_\_

**DRUGS**

**HOSPITALIZATION**

**NURSING CARE**

**DENTAL CARE**

**OTHER TYPES OF CARE**

**IS DISALLOWED FOR THE FOLLOWING REASON:**

**IS MODIFIED:**

Authorization issued for:

**IS AUTHORIZED:**

Date \_\_\_\_\_

Department of Public Welfare  
 Division of Medical Care

per \_\_\_\_\_

**LEO H. VOSBURG**  
 Commissioner of Public Welfare

Form M-13





SCHENECTADY COUNTY DEPARTMENT OF PUBLIC WELFARE  
VENDOR'S COST CARD

[illegible]



FORM 80-1517-2-4 GSA

INVOICES MUST BE IN QUADRUPLE & SENT TO DEPARTMENT OF PUBLIC WELFARE, COURT HOUSE, SCHENECTADY, N.Y.

DATE OF INVOICE

LEAVE THESE SPACES BLANK

AUDITED	WARRANT NO
---------	------------

APPROVED

CHARGE TO  
ACCOUNT NO.

CLAIM APPROVED FOR \$

SIGNED \_\_\_\_\_

ALGITOR

ALGOTON

**ASSIGNMENT OF CLAIM**  
Not to be used unless claim is assigned

STATE OF NEW YORK,  
County of Schenectady,

Dated \_\_\_\_\_ 19\_\_

\_\_\_\_\_ being duly sworn, says that he is the merchant named in and who has signed the aforesaid order or orders issued by the Department of Public Welfare for supplies to be delivered respectfully to and as stated herein; that the said supplies have been delivered to the parties to whom such orders directed them to be delivered and that the price charged for the same are the reasonable market prices therefor; that no price has ever been presented for furnishing of the said supplies and that no part thereof has been paid and there is now due and owing to respondent the sum of \$\_\_\_\_\_.

and set over unto \_\_\_\_\_ the sum or sums of money amounting to \$ \_\_\_\_\_ due and owing him from the County of Sche-  
nectady for the supplies furnished as aforesaid.

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_

Notary Public -- Commissioner of Deeds

Signature of Amigos L.S.

[illegible]

USE SUPPLEMENTARY SHEET FORM 30-A FOR LISTING ADDITIONAL ORDERS

STATE OF NEW YORK  
County of Schenectady

## VERIFICATION

(Here give name of person making affidavit, whether claimant, member of firm or officer of corporation) \_\_\_\_\_ being duly sworn says that

10. If individual, leave blank. If partnership, write "name of firm or partnership." If corporation, name of firm or corporation. If "President or  
11. If claimant whose name appears at the top of this form, the name of the claimant, firm or corporation, and the name of the labor organization, if any, and the work not performed or furnished in the name of or for the benefit of any of the above, then the said claimant is the real party in interest, that the contract, if any, was so made, and moneys expended as stated in claim have actually been performed, furnished and expended at the time and places and in the manner specified therein, and that the work was performed, Denonant further says claim is just and true, that no previous award of the same current prices and reasonable market value for labor or services has been made, and that no award of the same has ever been granted for the work or expense or for the same.

The claimant hereby certifies that there are no Federal or New York State awards included in this bill.

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 18\_\_\_\_

Notary Public — Commissioner of Deeds

Signature of Deponent.









